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ABSTRACT

A sample of collaborative experiments in nursing service and education in the Midwest are described in these conference proceedings. Section I presents "Unification, Reunification: Reconciliation or Collaboration," by Helen R. Grace, which discusses the conditions necessary and sufficient to produce a true clinical-educational conjoint relationship. Section II, "An Experience in Collaboration," by Geraldine Price and Peggy Gray, examines a federal- and state-supported system of highly successful Nursing Home Area Training Centers. Section III contains "Experience in Collaboration--Using Three Methods," by Sr. Rosalie Klein and Mary Jane Mayer, which details the working relationship between a community health nursing agency and nursing educational programs, whereby students are placed in the agency for guided basic experience. In section IV, a triad of views by an educator, a service director, and a new nurse graduate are provided in "The Need for Collaboration: A Statewide Nursing Consortium as a Facilitating Mechanism," by Elisabeth Zinser; "Perspectives of Nursing Service," by Beth Roder; and "Transition from School to Practice: A New Graduate's Perspective," by J. Jean Mellum. Finally, section V presents brief descriptions of additional examples of service/education collaboration. (RO)

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MODELS FOR COLLABORATION

Midwest Alliance in Nursing

Fall Conference Proceedings

Sept. 16, 1980

X 860 406

MODELS FOR COLLABORATION: NURSING SERVICE - NURSING EDUCATION

Proceedings of the Fall Workshop, Sept. 16, 1980
held in Rapid City, S. Dakota
by the
Midwest Alliance in Nursing, Inc.
1100 W. Michigan St. Indianapolis, IN 46223

edited by
Barbara B. Minckley, DNSc.
Executive Director

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SECTION I

Models for Collaboration: Nursing Service - Nursing Education

Acknowledgments

At a time when the Midwest Alliance in Nursing had just completed its first year of existence, the Fall Conference on Collaborative Models, summarized in this volume, was implemented in response to the vote of nearly 270 nurses at MAIN's Annual Program Meeting the previous April. Rozella Schlotfeldt, Ph.D., acting executive director of MAIN from April 1979 to July 1, 1980 had successfully guided the creation of the Midwest Alliance in Nursing during 1977 to 1979 with support funding from the Division of Nursing, DHHS.

In planning for this conference, Dr. Schlotfeldt wrote to the prospective speakers suggesting to them emphasis and content that would be most appropriate to give the audience a challenging range of collaborative options combining practice and education--options that would have appeal to both clinicians and educators. The speakers responded with enthusiasm bringing to the conference their experiences and intense interest in service/education collaboration.

Dean Helen Grace's philosophic keynote contrasted the old and the new with a touch of nostalgia, displaying the gallery of collaborative models in historic perspective. The presentations that followed moved to models of collaboration through teams, joint appointments, and to collaboration in a rural region. After each presentation the audience raised issues for discussion and debate. The two historic antagonists, clinicians and educators, finding themselves seated next to one another in the audience, took turns poking good-natured jests directed at each other's well-known weak spots. "Why can't the student have a better exposure to experience in community health nursing?" "Why should medical-surgical hospital nursing skills be the only ones emphasized in the basic program?" "Why can't the clinical staff have input into the educational program?" The result provided a host of suggestions for continued collaboration between education and service - a trend that is gaining momentum throughout the Midwest.

The changing times and equalization of status and earning power of clinicians with educators now opens many avenues for innovative service/education projects. It has fortunately become rare that any clinical setting remains isolated from the sway of an educational system and its students. This program offered real live examples of how continuing service/education collaboration had been established in a variety of settings, even overcoming resistance to do so. This volume is but a sampler of the collaborative experiments in nursing service and education in the Midwest for which MAIN, itself a combined service and education organization, was happy to play the role of sponsor.

MAIN is particularly indebted to the W. K. Kellogg Foundation for its continued support of nursing's, and particularly MAIN's, role in improving

patient care in the region; and for the personal commitment and assistance of Barbara J. Lee, Program Director for the W. K. Kellogg Foundation who has taken an active interest in the evolution of MAIN and its goals. We are also grateful for the planning and assistance of Annette Scheffel, Assistant Professor, University of Iowa, who chaired MAIN's first Program Committee; and the Program Committee members: Carolyn Littlejohn, Director of Education, Visiting Nurse Association, Milwaukee, WI; Mary Morris, Administrator, Nursing Service, Henry Ford Hospital, Detroit, MI; and Mary Lou Taylor, Director, Nursing Program, Johnson County Community College, Overland Park, KS.

Patricia Diamond, Chair
Governing Board - 1980-1981
Midwest Alliance in Nursing

Preface

Several articles and position papers appearing in nursing literature over the past two decades recommend that nursing faculties should regularly engage in practice and that the talents of nursing service personnel should be expected to contribute to the education of nursing students. Some of those recommendations, however, convey the underlying notion that faculty are not and should not be practitioners as an integral part of their faculty role and that nursing service appointees are not and should not be teachers of students, except as they serve as practitioner models executing their agency responsibilities. In contrast, other authors recommend unifying nursing services and nursing education, with a view toward eliminating all distinctions between professional appointees in the two kinds of institutions. The issues inherent in those dichotomous positions point up the need to search for creative ways through which to relate health care agencies providing nursing services and educational institutions offering programs of nursing education.

The interdependence of nursing schools and nursing departments of a wide variety of existing and yet-to-be-developed health care agencies resides in the very nature of both. Nursing services appropriately expected of health care agencies cannot be provided without the contributions of knowledgeable, competent, caring generalist and specialist nurses. The preparation of those professionals requires their having opportunities to learn in a variety of health care settings in which nursing practices are exemplary and in which nursing inquiry is continuously ongoing. Because knowledge is always efficient, there is need for thoughtful nursing practitioners to identify the particular knowledge they need but which is not yet available and for investigators to go in quest of it. And the ultimate test of the validity of

newly discovered knowledge lies in its translation into nursing practice that are then thoroughly tested and found to be efficacious. Nursing education and nursing practices then both change as a consequence of advances in knowledge and technology.

Midwestern nurses demonstrated their recognition of the inherent interdependence between and among all types of nursing service agencies and all kinds of educational programs preparing nurses when they established the Midwest Alliance in Nursing. The papers published herein demonstrate that the quest for creative ways to promote collaboration is vital and ongoing and that citizens served are those who benefit most from the innovations that are and will be forthcoming as a consequence of that search.

Rozella Schlotfeldt
Cleveland, Ohio
March, 1981

Models for Collaboration

Nursing Service - Nursing Education

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SECTION II

UNIFICATION, REUNIFICATION: RECONCILIATION OR COLLABORATION -

Bridging the Education-Service Gap*

Helen Grace, Ph.D., Dean, College of Nursing
University of Illinois at the Medical Center

Foreword

On Tuesday, September 16, 1980 MAIN sponsored a Fall Conference on the theme of effective strategies and models for linking nursing service more closely with nursing education. "Unification, reunification; reconciliation or collaboration--Bridging the Education-Service Gap"; was the title of the keynote presentation by Helen Grace, Dean, College of Nursing, University of Illinois at the Medical Center, Chicago, Illinois. Dr. Grace delves straight to the bottom of the conditions necessary and sufficient to produce a true clinical-educational conjoint relationship. She notes that commitment to the unification-concept and legitimizing of practice as part of the expected faculty role may require the greatest effort for changing fundamental attitudes of nurses in both realms. Academic goals are not service-oriented for the very good reason that if they were, knowledge would tend to be tied to service needs and could not advance beyond the requirements of the present. The student and researcher and indeed the clinician need time away from practice pressures to contemplate the meaning of practice and reach beyond existing knowledge for new ways to improve nursing practice or expand nursing knowledge.

To read between Dean Grace's lines:

Forces driving service and education apart

Lack of understanding of one another's requirements for goal fulfillment
Exchanges are characterized by mistrust, jealousy, and contempt
Lack of meaningful input or of responsibility: education for patient care; of service for what students are taught
Separate governances for service and education
Separate and sometimes mutually exclusive goals: service is patient care centered; education is student learning-centered
Rusty practice skills of faculty
Inability of service nurses to qualify for faculty positions
Rewards in completely different terms for service and education
Stressful service conditions - perceived elitism and "easy life" of educators
Salary differences
Inability to accommodate clinical research
Inability to appreciate the value of nursing theory, and the need to document nursing outcomes collectively, systematically to advance practice.

Dean Grace traces historical emphases in socio-political contexts to show how service-educational separation began in this country. A stupendous expenditure of effort was required by nursing to gain acceptance as a legitimate academic unit in the University. The threat of outside forces using the conflict as a means to keep nursing divided is yet another aspect of the precariousness of attempts to move practice and education closer together.

Seven transitional models are described and analyzed to categorize past and present designs for service-education relationships. They proceed, as has the very technology of nursing, from simple to complex, matching the current multihierarchal health center-community organizational interdependencies. These models show us clearly what has been tried and what needs yet to be invented. But above all let us begin with commitment to the concept of a true dyadic relationship for nursing in schools or practice settings.

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UNIFICATION, REUNIFICATION: RECONCILIATION OR COLLABORATION -

Bridging the Education-Service Gap

Helen Grace, Ph.D., Dean, College of Nursing
University of Illinois at the Medical Center

Introduction and Rationale

Early in 1979 a group of prominent nurse-educators convened under the auspices of The Robert Wood Johnson Foundation, met, and drafted the following position statement:

> Nursing's fullest potential in delivery of health care is contingent upon the unification of nursing service and nursing education. Unification is the mechanism to enhance the quality of care, stimulate research into nursing practice questions, infuse curricula with clinical realities, provide exemplary learning opportunities for nursing students, and facilitate entry for nurses prepared for both basic and advanced practice.
>
> Some unification models which have been developed and tested demonstrate the potential of nursing to achieve these goals. There is an urgent need for nursing educators and nursing administrators to collaborate in the development and testing of additional models. In this process some of the issues that need to be addressed are:
>
> (1) Developing commitment to the concept.
> (2) Legitimizing nursing practice as an integral part of faculty role.
> (3) Developing the organizational mechanisms and professional relationships to support faculty practice, research, and teaching.
> (4) Designing incentives for faculty to promote integration of practice into research and teaching, such as appointment, promotion, retention, and tenure criteria.
> (5) Developing financial resources and mechanisms to implement the concept.
> (6) Building a data base to document outcomes.
> (7) Creating strategies and forums for dealing with joint practice issues.
> (8) Restructuring of nursing curriculum.
> (9) Providing opportunities for faculty development of new roles.

This position statement has since been published in all of the major nursing journals, and has found its way into the agendas of most of the prominent nursing organizations. As a result the following resolutions and statements are illustrative of the response:

ANA RESOLUTION 46: Resolved that the American Nurses' Association strongly endorse the development and systematic evaluation of collaborative models between nursing education and nursing services to improve the quality of nursing care, enhance the quality of learning opportunities and promote research (American Nurses' Association, 1980).

AMERICAN ACADEMY OF NURSING: Resolved that the American Academy of Nursing endorse the idea of cementing the relationship of service and education, through such devices as faculty practice, joint appointment, shared salaries, clinical faculty appointment, collaborative research and other mechansims (American Academy of Nursing, 1979).

AMERICAN ASSOCIATION OF COLLEGES OF NURSING: Based on the assumption that client care is the raison d' etre for all nursing roles, faculty practice is perceived as an important link in improving communication between nurses who have primary responsibility for education and those who have primary responsibility for client services. Improved communication about common goals, the art and science of nursing practice, and problem-solving approaches offers the potential for improved client care, increased quantity and quality of clinical research, and greater role satisfaction for all who practice nursing (American Association of Colleges of Nursing, 1979).

As this debate develops the terms used to describe the end goal shift. The initial statement, directed toward unification as an end, has become modified as each group begins to engage in debate. Reconciliation is the term proposed by the American Academy of Nursing, while others argue that what we are talking about is reunification, implying a return to what we once had. Still others speak of collaborative models, or development of clinical practice roles for faculty. In the midst of all of this rhetoric and debate it is important to look at some of the central issues involved, and from this analysis purpose some principles for guiding further development of models to bridge the service education gap.

Nursing education has encountered many obstacles in moving from nurse "training" to nurse "education". Ironically, the Florence Nightingale school "had as its aim the training of nurses who would improve the care of the sick" (Smith, 1965, p. 54). An important goal, then, of nurse training at the beginning was that of improving patient care which has some real implications for the educational process. The Bellevue Training School for Nurses founded in New York in 1973 in contrast listed as its purpose: "to provide trained nurses" (Smith, p. 54). The difference in goals between the Nightingale school and those established in the United States is a significant one. As Smith notes: "The word 'improve' which is not present, suggests active change, growing, learning. The word 'provide' suggests something or somebody already capable of performance" (Smith, p. 54). Smith has cogently identified one of the underlying conflicts that persists to this day, and that is the differentiation between education for a profession or training for a trade. In the former

definition it is assumed that to perform as a professional nurse requires an adequate scientific base upon which practice rests. The graduate of an educational program supposedly has a broad base of scientific knowledge upon which decisions in the practice domain are based. In contrast, the person who has been trained, predicated their practice upon observation of others in the setting, learning of procedural rules, and following of orders. As one practices over a period of time, this is coupled with observations of cause and effect relationships that might serve to provide impetus for greater innovation in practice. As nurse training developed within the United States a basic underlying bias has been toward performance, rather than toward the knowledge base possessed by the practicing nurse upon which decision making rests. With training as a predominant goal, the education of nurses was secondary to their role in providing services to patients. As Christy notes:

> In the great majority of schools there were no instructors. and students were thrust into hospital wards to learn "catch-as-catch can" by watching and imitating other students. At the turn of this century, the nurse known as the Training School Superintendent taught what little there was in the way of classroom instruction in nursing, while physicians "guest-lectured" here and there on various aspects of patient care" (Christy, 1980, p. 493).

In many instances the training school was totally merged within the hospital, and students formed the predominant work force.

Conflicts between the service mission of the hospital and education for nurses, then became a predominant theme. As Holtzhausen notes in 1946:

> When a school is part of the hospital framework with responsibility both for right service to the hospital and sound education for the student nurse, nursing is unable to give satisfaction to the public at large, to the medical profession, to the hospital or to its practitioners. The two objectives of the traditional American school of nursing (1) to prepare students to practice nursing, and (2) to provide a nursing service at lowest cost to the hospital sick have always been in conflict with each other, for they have placed the student's professional education in competition with the needs of the hospital. The specific demands and conditions in each have made accomplishment of the other impossible. To guarantee a service that is regular, continuous, adaptable with completely competent and safe nursing care of patients by a student group is impossible if one must provide at the same time for free participation of the student in an educational program that is professionally and academically sound. Nursing education has philosophies, aims, standards, studies, and programs of work. To nursing education the student is at the center of the program whereas hospital nursing service revolves around the care of the patient (Holtzhauzen, 1946, p. 550).

As a means of resolving this conflict, nursing education opted to move out of the hospital setting and into the academic mainstream. Ironically, medicine faced with the same types of dilemmas, has been able to maintain its place within both systems, while nursing education has been confronted with uneasy and shifting alliances within both systems. Separation of nursing education out of the service delivery system was deemed a necessary step if the transition from "training" to "education" was to be achieved. Nursing education, in its move out of hospital settings and into academic institutions, has had tremendous obstacles to overcome, most notable that of becoming a bona fide and accepted academic program that is so recognized in University and College settings. In this transformation stage, tremendous energies have been invested in curricular design, achieving academic credentials for nursing faculty, and carefully structuring clinical learning experiences to meet objectives flowing from the academic content of the program. In this phase, students' experiences in the clinical laboratory have been carefully structured and controlled so that they are guided toward achievement of very course-specific objectives. As a result, students graduating from nursing <u>educational</u> programs frequently have difficulty in making transition to active practice settings in which the expectation is that nurses are <u>trained</u> to perform the multiple tasks that confront the nurse in practice. Christy, referring to comments made by Harry Martin in 1959 notes that:

> one outstanding result of the change to the role of 'nothing but teacher' has been that nurses can become teachers of nursing by virtue of academic degrees with little or no teaching experience. The clinically inexperienced teacher is vulnerable to criticism by experienced practitioners and may demonstrate lack of awareness of the pressures and problems impinging upon nursing service. Additionally, inasmuch as she is not part of nursing service, the faculty member has no authority to direct and control the situations in which her students are obtaining their most vital professional experience. She becomes a guest of the hospital and of the nursing service and is rarely able to take action without having to clear with nursing service representatives (Christy, 1980, p. 496).

Increasingly, nurse educators and nurses in the practice setting find themselves in adversary positions. The nurse educator, whose only role is that of guest within the clinical setting, too frequently assumes the role of critic. With a sound base in what clinical practice "ought to be" the nurse educator observes practice as it "really is". In attempting to provide the student an education in nursing as it "ought" to be practiced, the nursing instructor isolates the students from contact with nurses in practice that might serve as contaminants. On the other side, nurses in practice bemoan the fact that the graduates of academically based nursing programs cannot enter into practice roles the same way in which graduates of more familiar diploma programs did. Nursing educators are perceived as living in an ivory tower, removed from the realities of nursing practice, and preparing students with little immediate usefulness in the active world of nursing practice.

This adversary relationship creates serious problems, particularly to a profession that has repeatedly been controlled by outside forces that keep us divided. The central issue in bridging the service-education gap is that of finding ways of doing so that will strengthen us rather than serve to continue to maintain us in our vulnerable and dependent position. One danger is in reversion to the previous system. As Christy notes: "History does tend to repeat itself, and in nursing we never seem to achieve a midpoint for the swing of the pendulum. When will we learn to profit from the problems of the past and attempt to strike an appropriate balance for the future?" The challenge before us is that of plotting our course in such a way that the strength of nursing education and nursing practice may be combined to garner us our appropriate place in health care delivery.

Traditional Nursing-Education Practice Models

For purposes of clarification it is important to look at some organizational models that depict the relationships between nursing education and nursing practice settings. These models are conceptual models of what I believe to be the major distinctions in the relational patterns between nursing education and nursing practice over time.

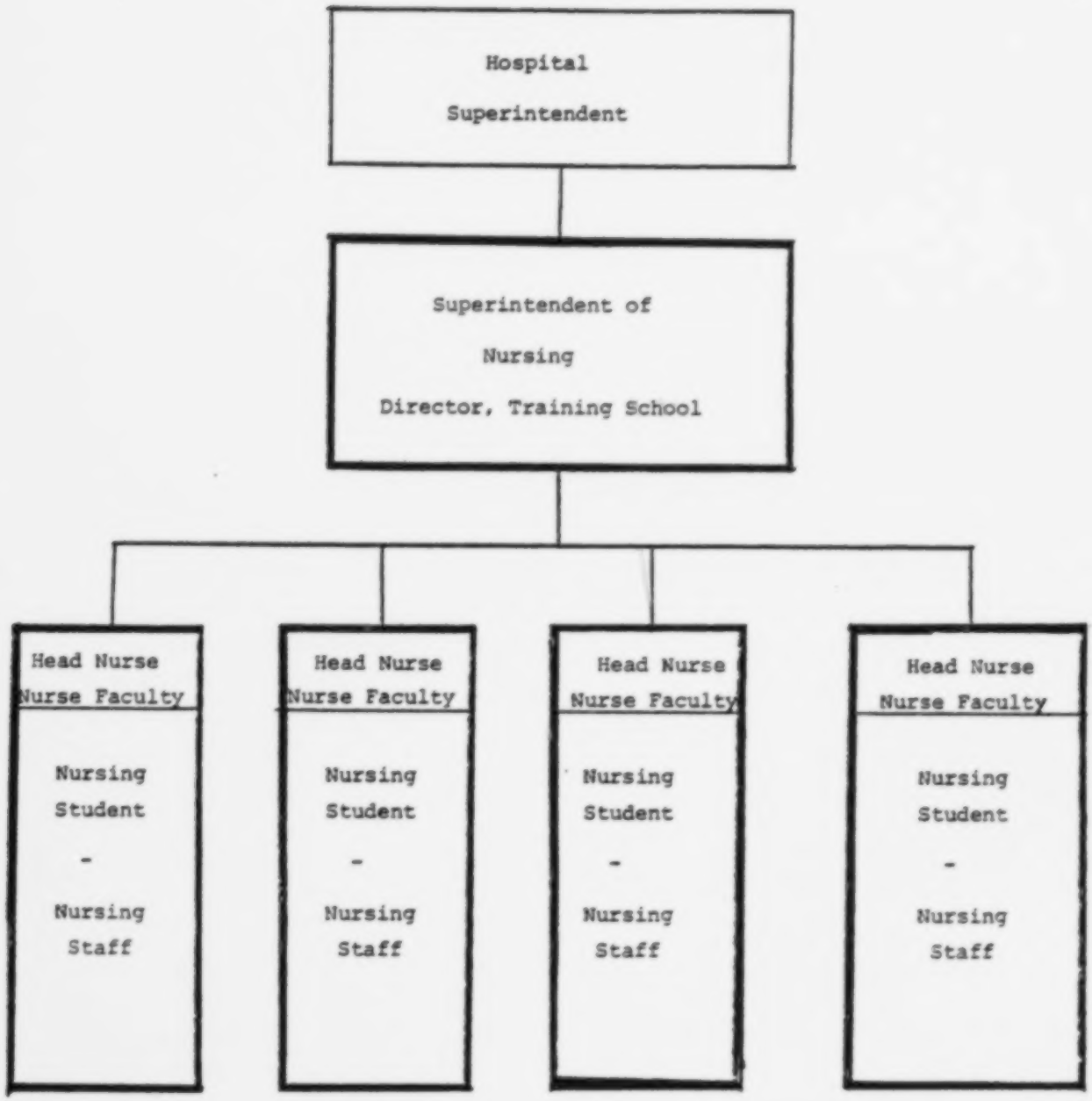
The first model of organization for nursing education (or more accurately "training") in the United States placed the nurse training program squarely under the administrative organization of nursing service within the hospital setting. Model I depicts these relationships. This original Training School model was the ultimate in unification. Throughout the entire system responsibilities for education and service were totally merged and under one governance structure, that of the Hospital.

Following the Goldmark report (1923), reforms were supposedly made in Nursing Education, the first being the development of quasi-educational programs within hospital settings. These organizational patterns persist to this day in the structure of diploma nursing education. Model II depicts this organizational structure. In this organizational pattern, nursing service and nursing education are parallel systems under the common governance structure of the hospital with its primary mission of providing patient care.

As nursing education moved from hospital settings into academic structures, nursing education and nursing service were then in separate governance structures with differing societal missions: the hospital, that of providing patient care, and the university, that of generating and transmitting knowledge. Model III depicts the most common patterns of relationships existing between nursing academic programs and clinical agencies that serve as the laboratory for the teaching of nursing. Most commonly this constitutes a contractual arrangement between organizational structures. In this model, responsibility for nursing education and nursing practice are clearly separated and under separate governance structures. Faculty and students enter practice agencies clearly as

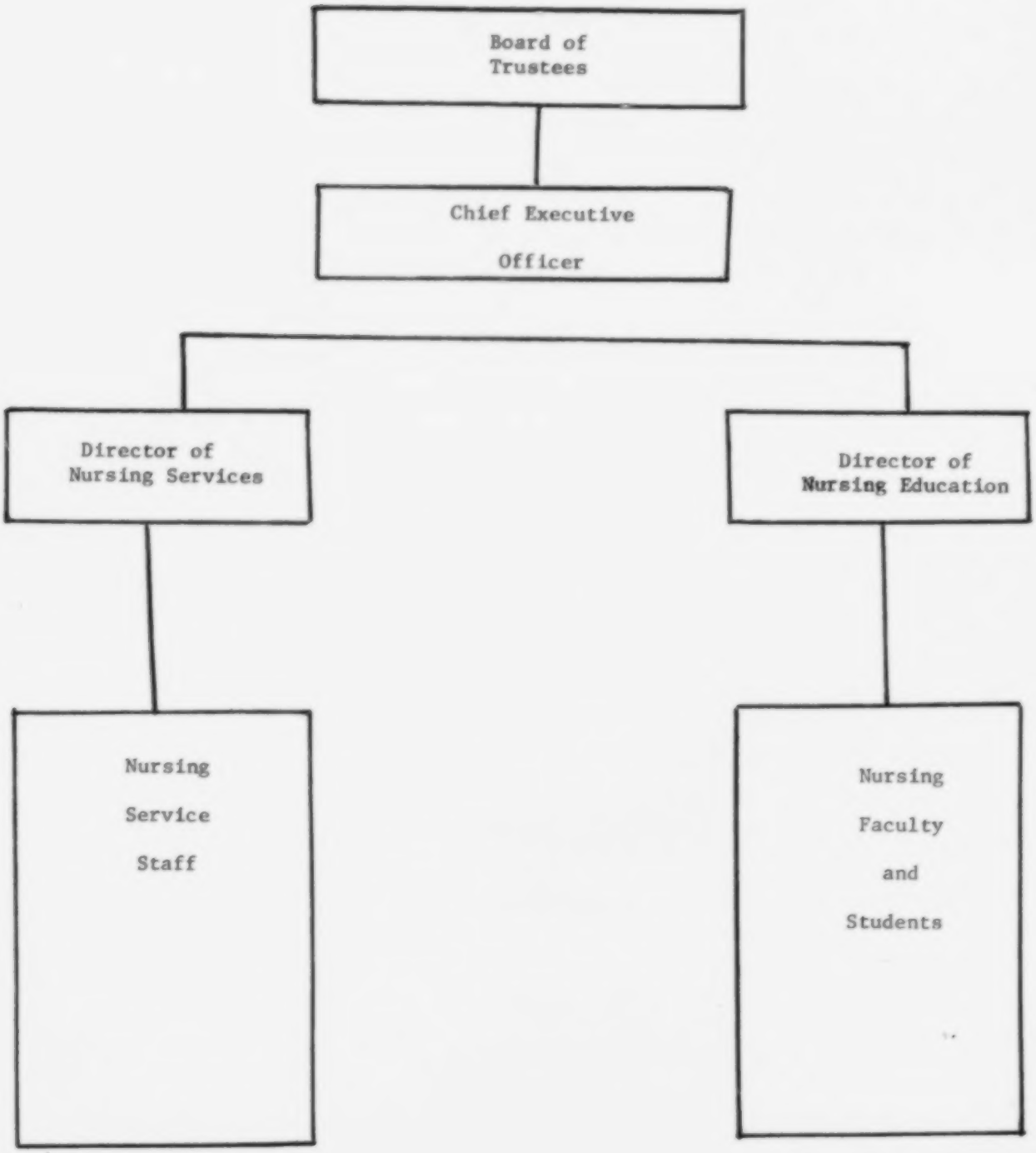
MODEL I

TRAINING SCHOOL ORGANIZATION



MODEL II

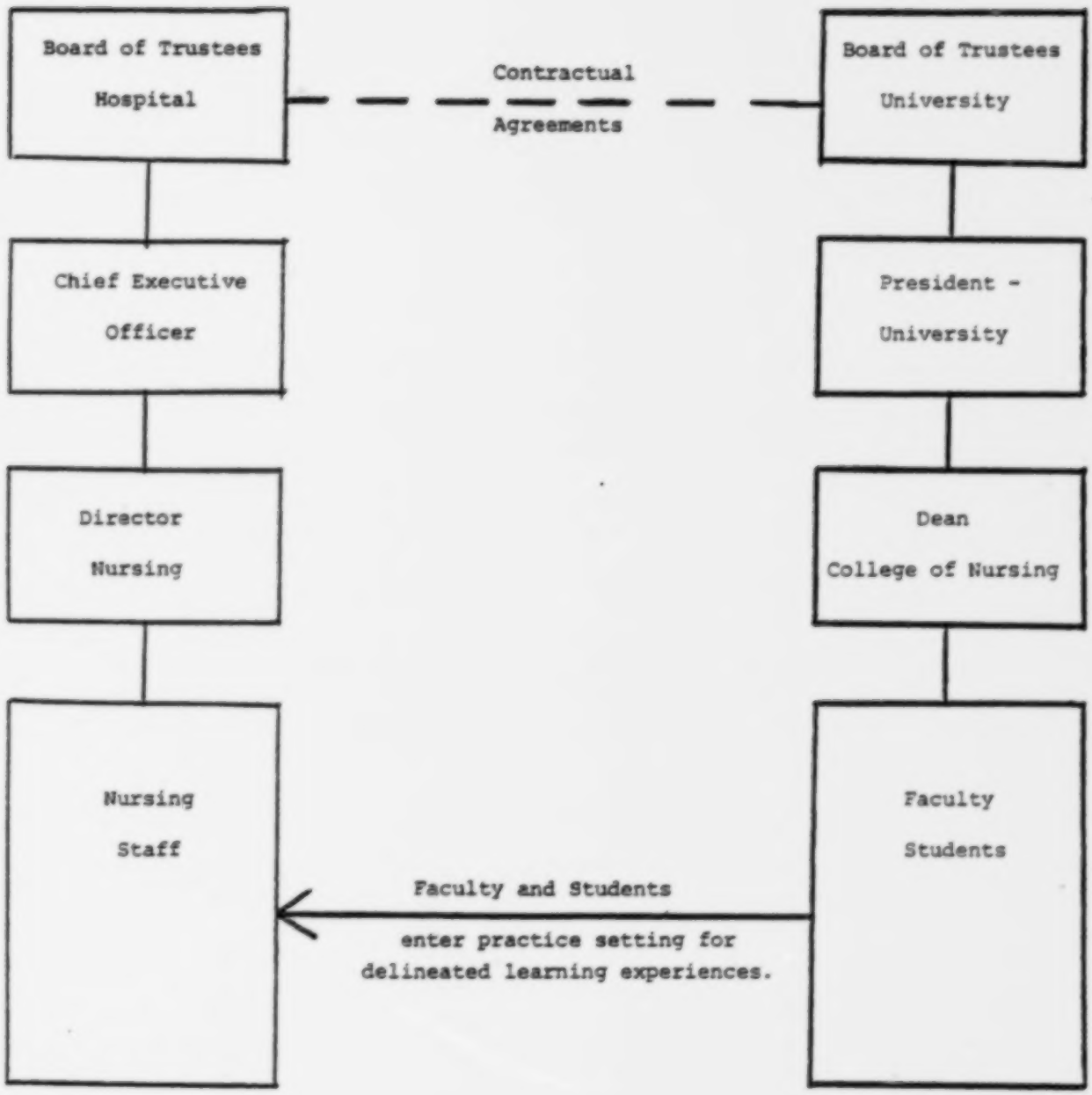
NURSING EDUCATION WITHIN HOSPITAL STRUCTURE



MODEL III

CONTRACTURAL AGREEMENT BETWEEN

EDUCATIONAL AND SERVICE AGENCIES



guests for specific learning purposes. Responsibility for patient care remains with the nursing staff within the setting. This is the most common pattern of organization today, and the one now identified as in need of correction. In the views of the critics of this organizational model, the need is for reunification of nursing education and nursing practice, but as has already been noted, it is important that in this process we do not return to the ultimate in unification depicted in Model I.

Innovative Unification Models

Dorothy Smith, the Dean of the School of Nursing at the University of Florida, was the first proponent of unification of nursing service and nursing education in the late 50's. Smith, in proposing a unified model, looked to medical education as the pattern:

> Teaching hospitals have always been an integral part of the beginning education of medical students and the continuing education of medical faculty and practitioners. There is a medical hierarchy based on knowledge and skills in dealing with medical problems of patients. The various levels of house staff, the medical students, and the clinical medical faculty form a cohesive learning-teaching-service group, and together apply their knowledge and skill to the solving of patients' medical problems. They ask questions of one another. They are scientific investigators--some with much knowledge and skill, some with little (Smith, 1965, p. 54).

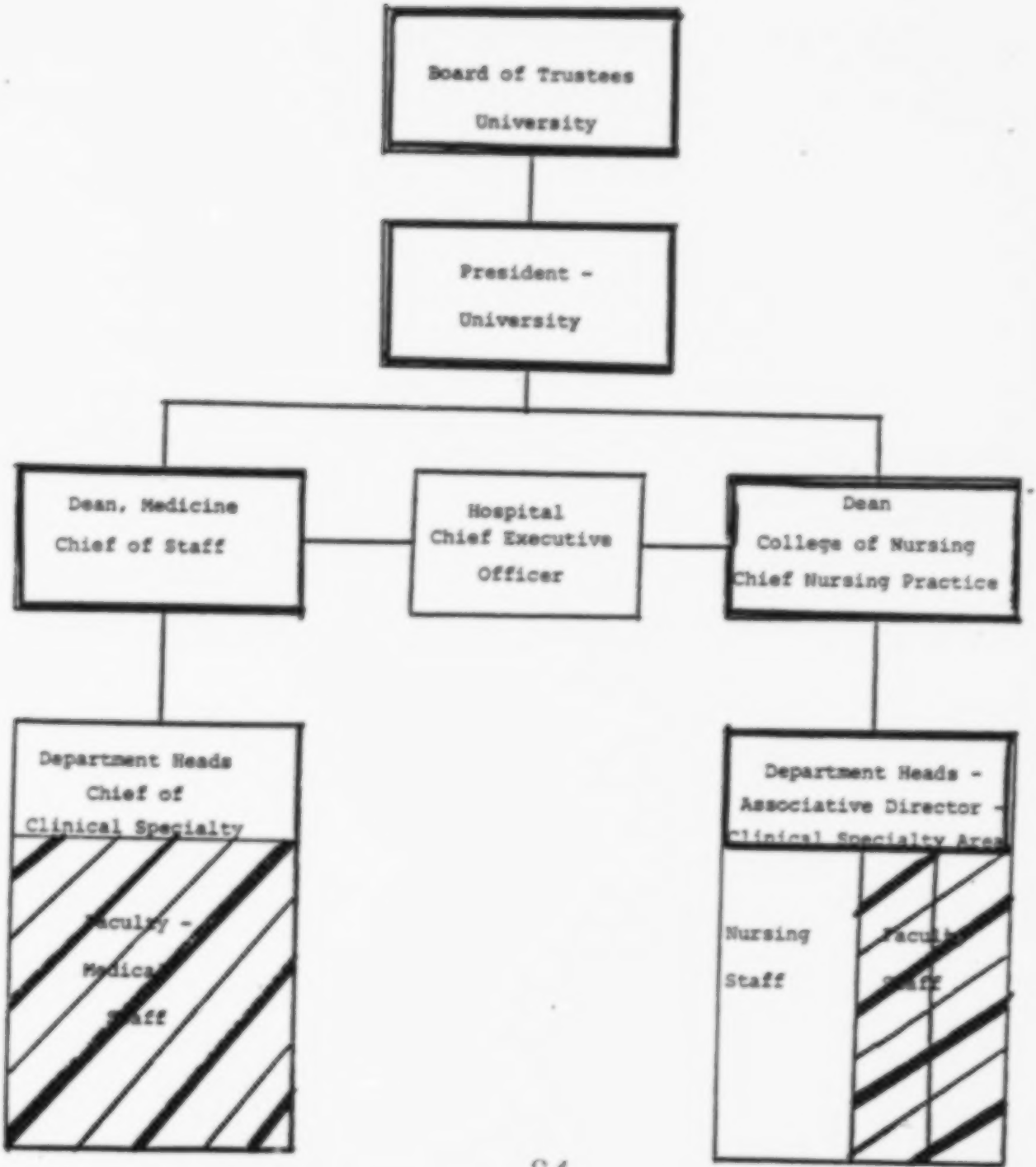
Based on these observations, Ms. Smith then developed an organizational structure in which she, as Dean of the Nursing College, also served as Chief of Nursing Practice at the University Hospital. Model IV depicts the organizational structural model for nursing that parallels that of the traditional medical school organization.

In viewing this model it is important to keep several points in mind. 1) This is a model for a setting in which a hospital is part of the University. In this setting, the overall mission governing the hospital involves research and teaching. University Hospitals exist to meet the research and teaching needs of faculty in the health science disciplines. Most frequently this mission has been defined solely in terms of medical education, and it is important that in such a system nursing be recognized as an equal participant. 2) A further problematic area surrounds the relationship of the Chief Executive Officer of the Hospital to the Medical and Nursing hierarchies. Traditionally, the Chief of Nursing reports to the Chief Executive Officer of the Hospital. If the Dean of Nursing, who also holds the position of Chief of Nursing, were to so report, her position within the University hierarchy would be compromised. 3) While there are similarities between the organization of Medical education and Nursing education, there are dissimilarities that must be recognized. In Medicine, all of the practicing physicians have an equivalent base of preparation, the M.D. degree. In nursing

MODEL IV

UNIFICATION MODEL FOR NURSING PARALLELING

THAT FOR MEDICINE



this is not so, and the majority of nurses in the practice setting are prepared at an educational level below that of the degree offered by the nursing educational program of the University. Therefore, a large number of this nursing population are not qualified to hold faculty positions. A further complication surrounds the nature of nursing and the twenty-four hour a day responsibilities of the Department. It is of interest to note, that just recently the University of Florida Hospital has become a private entity and is no longer under the University governance structure. The basic structure developed by Smith has not survived, and the pattern of nursing education in Florida at this time is similar to that described in Model III.

Two models closely paralleling this original unification model are those developed at Rush University in Chicago and at the University of Rochester. Within the Rush model the educational and service systems are totally merged throughout the organizational structure. In this structure, for example, Associate Deans within the Academic Structure are also administratively responsible for service delivery so that a nurse might be titled as Associate Dean for Undergraduate programs, and Associate Director for Community Health and Gerontological Nursing. Positions at this level are broad in scope. At the Department level, Heads of clinical departments in the academic program are also heads of their respective clinical services. At the practice level, teacher-practitioners carry dual responsibility for the teaching program as well as the care of patients. Christman speaks to the key role of the nurse-practitioners in this system:

> Practitioner-teachers are in an advantageous position to serve as link pins between the theory and content of science and its application to practice. By cooperating with students in clinical settings, they are behavioral models of expertise. Imagery is important in learning how to practice. If students do not have their teachers as behavioral models, they will model their clinical behavior in the fashion of those they observe, regardless of the competence of these active practitioners. Undoubtedly, strains between students and teachers will increase if they do not function as practice models. By acting as consultants to other nurses on the staff, practitioners-teachers can raise the quality of the overall endeavor (Christman, 1976, p. 15).

It is important to note, that the Rush model is developed in a University setting that is described as a "single-purpose University" directed toward health science education, and is not located within a general university setting. This is the chief differentiating feature of this model from that depicted in Model I. While the integration between practice and education is achievable within this model, the problematic features of the early "training" school models persist, namely, that the demands of the active service setting frequently take precedence over the need to maintain a quality educational program. Also, while some

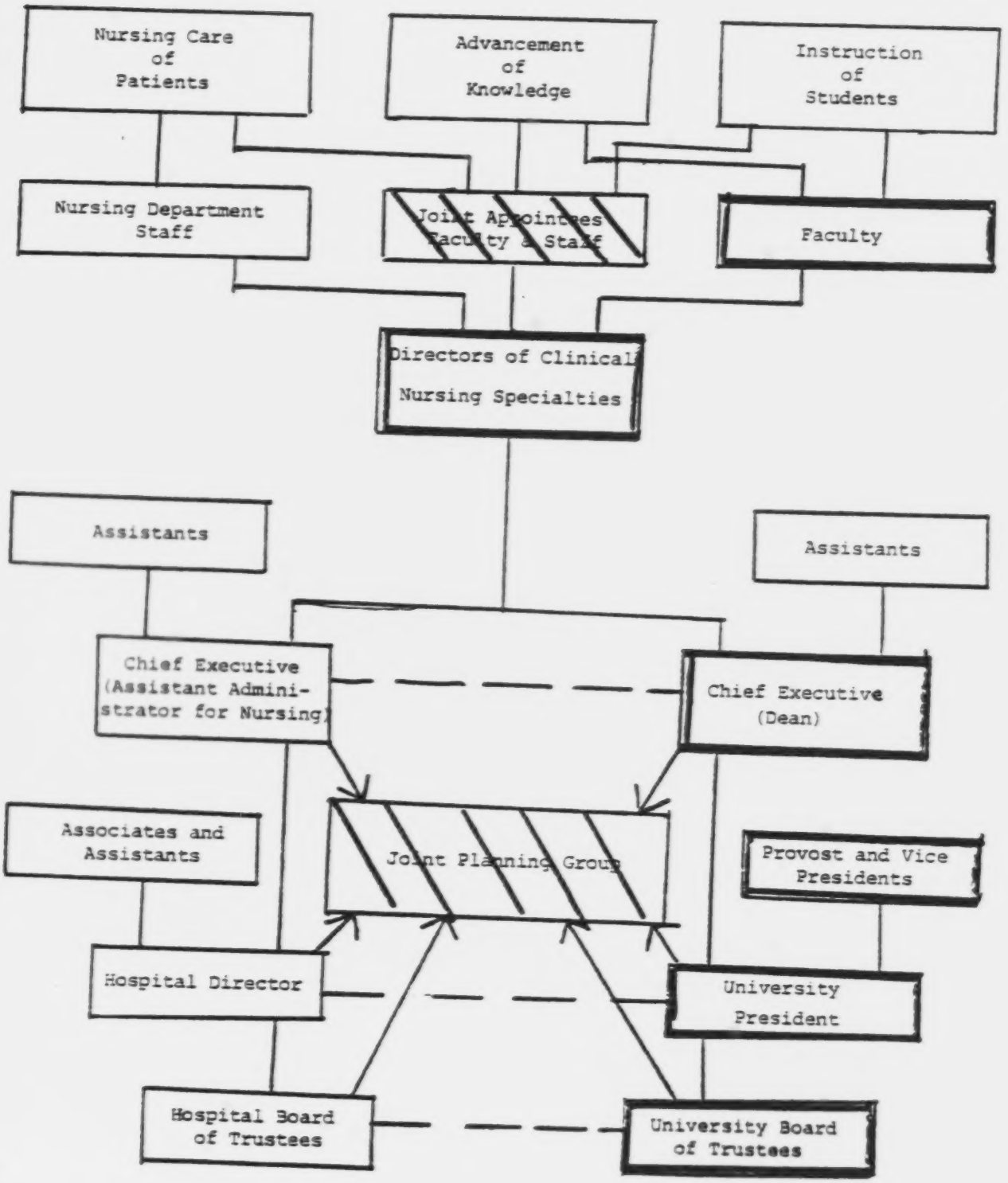
nurses thrive in a system such as this, others find it difficult to address both the responsibilities to service delivery and the educational program simultaneously. Scope of responsibility is extremely braod, and not all nurse educators-practitioners are able to function adequately in such a system.

The University of Rochester, while similar, has some noteworthy features. Organized as a school of Nursing in 1971 "it was proposed that nursing service and nursing education be integrated under the leadership of the dean for nursing in order to: (1) provide a realistic educational program for students; (2) upgrade nursing practice and improve patient care; and stimulate appropriate clinical research" (Powers, 1976, p. 484). As with the Rush model the organizational structure unifying the position of Dean and Director of Nursing was designed at the time the educational program was initiated. These systems were designed from the outset as unified systems, and have not had to confront the issues surrounding transformation of pre-existing organizational structures. Unlike the Rush system, the Rochester model has built within it, certain nursing positions which are specific to the educational system, as well as positions specific to nursing service delivery. Responsibility for day to day management of nursing within the hospital setting is vested in an Associate Dean and Director of Nursing practice. Similarly, Associate Deans have responsibility for programmatic direction of the educational program as a sole responsibility. In this model, careful attention is directed toward the preservation of quality in both practice and education.

Perhaps the most thoroughly described model in the nursing literature is that developed at Case Western Reserve University in Cleveland. In this model, careful attention has been directed toward fully conceptualizing a total system. Each step of development and implementation has been carefully described, and an extensive evaluation reported. For descriptive purposes this may be called a quasi-unified system. Within this organizational structure responsibilities for nursing service and for the academic program are divided between a director of Nursing Service who also holds a faculty appointment within the School, and the Dean of the School of Nursing. A Joint Planning group serves as a unifying structure between University and Hospital administration. Other main points of unification are at the Department Head level, with Heads responsible for both service delivery and the educational program in their respective specialty areas. Model V depicts this organizational structure. Within this organizational model, the Heads of Departments who also are the Directors of clinical divisions within the practice setting report to the Dean on the Academic side, and to a Director on the service delivery side.

While these unification models have demonstrated some real gains to be achieved in a closer working relationship between nursing education and nursing practice, they are not appropriate to all academic programs and practice settings. Many academic programs and the practice settings with which they are affiliated are under separate and many times multiple governance structures. Safeguards need to be built into the system so

MODEL V


Nursing Care of Patients
Advancement of Knowledge
Instruction of Students
Nursing Department Staff
Joint Appointees Faculty & Staff
Faculty
Directors of Clinical Nursing Specialties
Assistants
Assistants
Chief Executive (Assistant Administrator for Nursing)
Chief Executive (Dean)
Associates and Assistants
Joint Planning Group
Provost and Vice Presidents
Hospital Director
University President
Hospital Board of Trustees
University Board of Trustees

that the quality of education is maintained and not sacrificed to the heavy demands of the service setting. If the educational program is not safeguarded, there is danger that the system will revert to one in which the educational needs of students are again subordinated to the demands of the service agencies. In constructing unification models, it is extremely important that the positioning of nursing vis a vis other health science disciplines be a primary consideration in the construction of the organization. Further, any unification system must build upon mutual respect between nurse educators and nurse administrators. While nursing education has been engaged in a struggled to gain autonomy and recognition, nursing administration has similarly fought for its rightful place in hospital administrative structures. In many instances, the attempt to build a unification model is viewed by service staff as educators trying to "shape up" the practice setting.

Remembering that the mission of an academic program is that of generating and transmitting of knowledge, and the mission of the practice setting is directed toward the provision of patient care services, mutual respect and support of these goals must be built into any unified system. It must be noted too that some academic programs cannot be accommodated within the hospital practice setting. Community health nursing is a case in point. In designing unification systems these limitations must be identified and provision made so that these vital components of the academic program are supported and addressed.

In summary, unification models, while accomplishing much in bridging the education-service gap, are not a universal panacea. Given the need for closer alignment between education and service, alternate models are needed so that problems resulting from the service-education gap may be more adequately resolved.

Proposed Models for Bridging the Service-Education Gap

As noted earlier, considerable attention is currently focused on building closer working relationships between nursing education and nursing practice. In participating in discussions with colleagues throughout the country, a number of approaches are being made to address these issues. For purposes of discussion, emerging models are categorical as collaborative, affiliative, and independent faculty practice models. In this discussion, the University of Illinois is the major refferent; however, this does not mean to imply that others are not struggling with these same issues.

Collaborative Models

In response to concern about the nurse shortage in University Hospital and what could be done to rectify the situation, it was shown that the staffing problems were symptomatic and were only reflections of a more significant basic problem. Specifically, it was recognized that the hospital had been totally organized to meet the needs of the

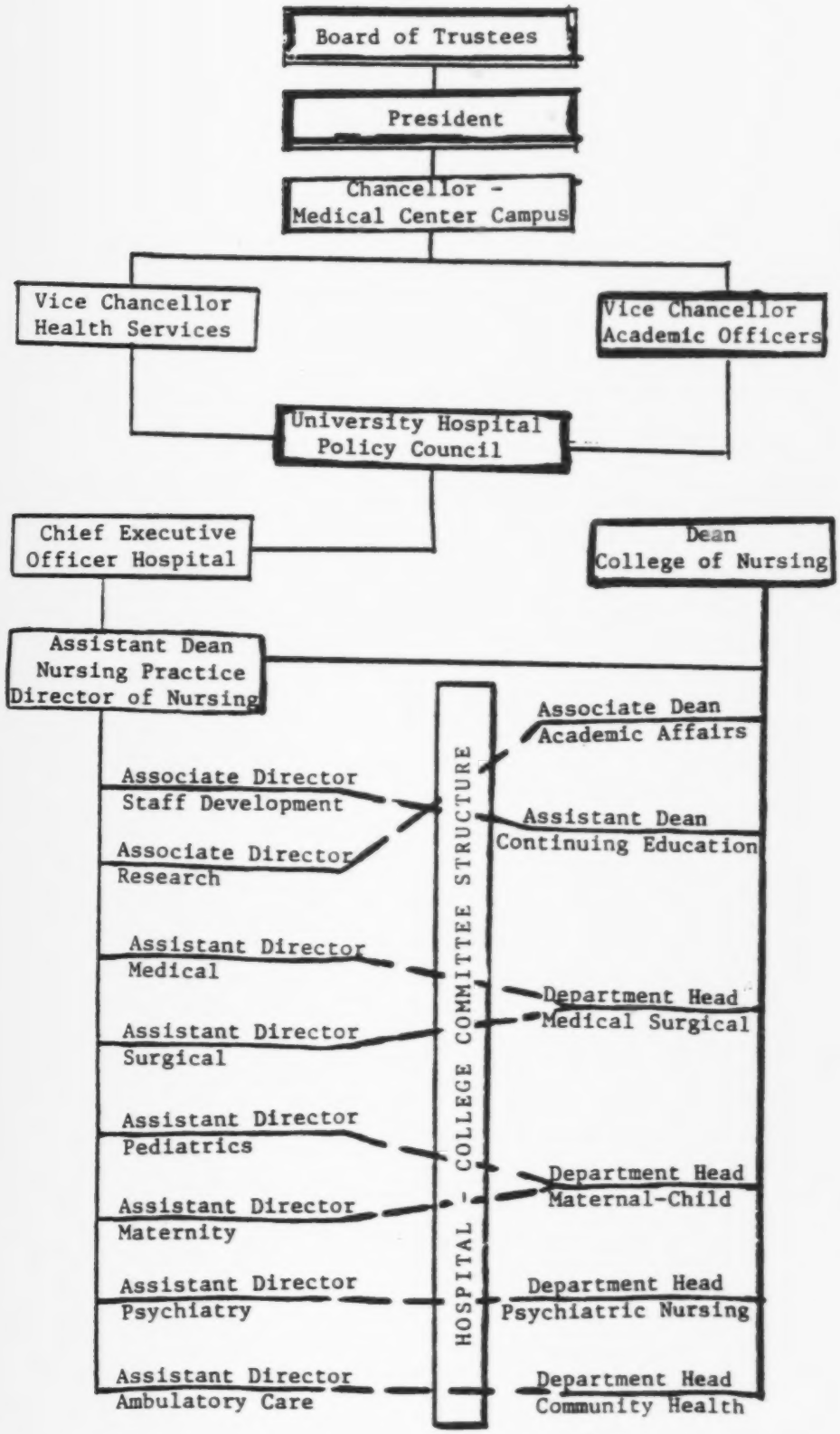
College of Medicine with little consideration of the needs of the other academic units of the Medical Center. After one year of effort to change this policy, a new position was clearly articulated that: "the University Hospital serves as the laboratory for the teaching and research programs of all academic units on the campus." With this new policy position, nursing services within the University Hospital have begun to be upgraded. The connecting links are now being forged between nursing services in University Hospital and the faculty of the College of Nursing. Along with the work that is being done between nursing faculty and staff, an overall governance structure for the hospital has been developed that assures participation of the Dean of the College of Nursing in policy making for the hospital.

The goal between nursing education and nursing service is patterned after a collaborative model. A systems perspective is most useful in conceptualizing this model. First steps in constructing it have been to develop two strong and compatible systems in the organization of nursing service within the hospital, and in the organization of the College of Nursing. The Director for Nursing serves also as an Assistant Dean for Nursing Practice within the College structure. In the year following the appointment of the Director, 100 additional nurses have been employed in University Hospital, and ten Master's prepared clinical specialists have been incorporated into the practice setting. The goal has been first to build a staff of nurses in the practice setting adequate both in number and in their credentials, and second, to have these clinical experts begin to interact on a peer basis with faculty of the College of Nursing.

One pitfall to be guarded against is the attempt to upgrade the service delivery system by infusing faculty into the practice setting, for which the educational program is not reimbursed. An important precondition, prior to implementing formal collaboration between systems, is that there be assurance that neither the funding base for nursing practice nor that for nursing education would be eroded in the process. Within the College of Nursing a reorganization plan was approved and implemented during this same year. With both structures clarified, the next steps were those of building links between systems. First, it was necessary to identify clearly the types of participation both faculty and nursing staff wish with one another. An all-day retreat served to surface all of the angry feelings that have traditionally built up between nursing faculty and those within the practice setting. Faculty expressed their very real wish to be engaged in issues related to quality of patient care, while nurses within the practice setting spoke of their interests in being involved in issues relating to the education of students. From this retreat, a Hospital-College coordinating council has been formed, composed of the leadership of both the College of Nursing and the Nursing Service within the hospital. This coordinating council will clarify goals and directions of our collaborative efforts. In addition, the committee structure of both the hospital and college have been reviewed, and membership of faculty on hospital committees, and of nurses from the hospital on college committees proposed.

MODEL VI

COLLABORATIVE MODEL



Additionally, planning groups between the Departments of the College and the parallel clinical specialty services within the hospital are engaged in discussing ways in which they might more closely interface. Identification of logical areas of collaboration is also ongoing. A position of Coordinator of Clinical Research has been established within the hospital, jointly funded by the College. Some research projects in Nursing Service have already been identified in which faculty of the College of Nursing are engaged. Currently an exploration is being made of the possible interface between the Continuing Education activities of the College and the Staff Development department of the College. Although firmly committed to a process approach in developing an organizational structure this structure is not as yet fully developed.

Model VI provides a conceptualization of the current organization at the University of Illinois. Within this system the Assistant Dean for Nursing Practice is accountable to the Dean for assuring that the needs of the College of Nursing for its educational and research programs are addressed, and to the Chief Executive Officer of the Hospital for the day to day management of the Nursing Department. Relationships between Department Heads of the College and the parallel departments of hospital are consultative in nature, and as joint planning proceeds between the College and the hospital, a system of joing appointments is beginning to emerge. The model that is developing in Medical-Surgical nursing is one in which the hospital and college collaborate in employment of a Clinical Specialist in the Hospital and a Nursing faculty member in the College. A pattern of exchange is worked out in which participation of the clinical specialist in the teaching program is defined, and the reciprocal role of faculty within the clinical setting is also delineated.

Affiliative Models

Not all academic programs in nursing are located in a setting in which a Hospital is part of the University structure. Even in those Health Science centers having a teaching hospital as part of the structure, not all academic programs of nursing can be accommodated within that one setting. Traditionally, placements for nursing students in extra-university settings have been managed through a multicontractual model. If the goal is that of bridging the service-education gap, an affiliative model might more appropriately serve this end. To affiliate means "to connect or associate oneself with" in contrast to a contract in which agreements are reached regarding the terms for specific clinical experiences of students. Affiliation implies a much closer connectedness and longer lasting association between parties, and includes a set of rights and responsibilities of the partners involved.

The University of Illinois is in the process of building affiliative agreements with a limited number of clinical practice agencies that are adequate to accommodate the teaching needs of the College of Nursing. This affiliative network is being built upon a set of agreements initially developed between the College of Medicine and six hospitals in the

Metropolitan Chicago area, originally chosen as sites appropriate for Undergraduate Medical Education. With a belief and commitment to interdisciplinary education, the College of Nursing and representatives from this six hospital network have engaged in discussions leading to the establishment of affiliative agreements. Under the umbrella of an overall University-Metropolitan Group of Hospitals Steering Committee the Nursing Committee has worked toward the following goals:

1. To expand the baccalaureate enrollment of the College of Nursing to accommodate the needs for increased numbers of baccalaureate prepared nurses, particularly those nurses with diploma and A.D. degrees, wishing to complete a baccalaureate degree.

2. To move currently existing diploma schools of nursing into the framework of generic baccalaureate education through an affiliative process.

3. To make graduate offerings more readily accessible to nurses within the participating hospitals.

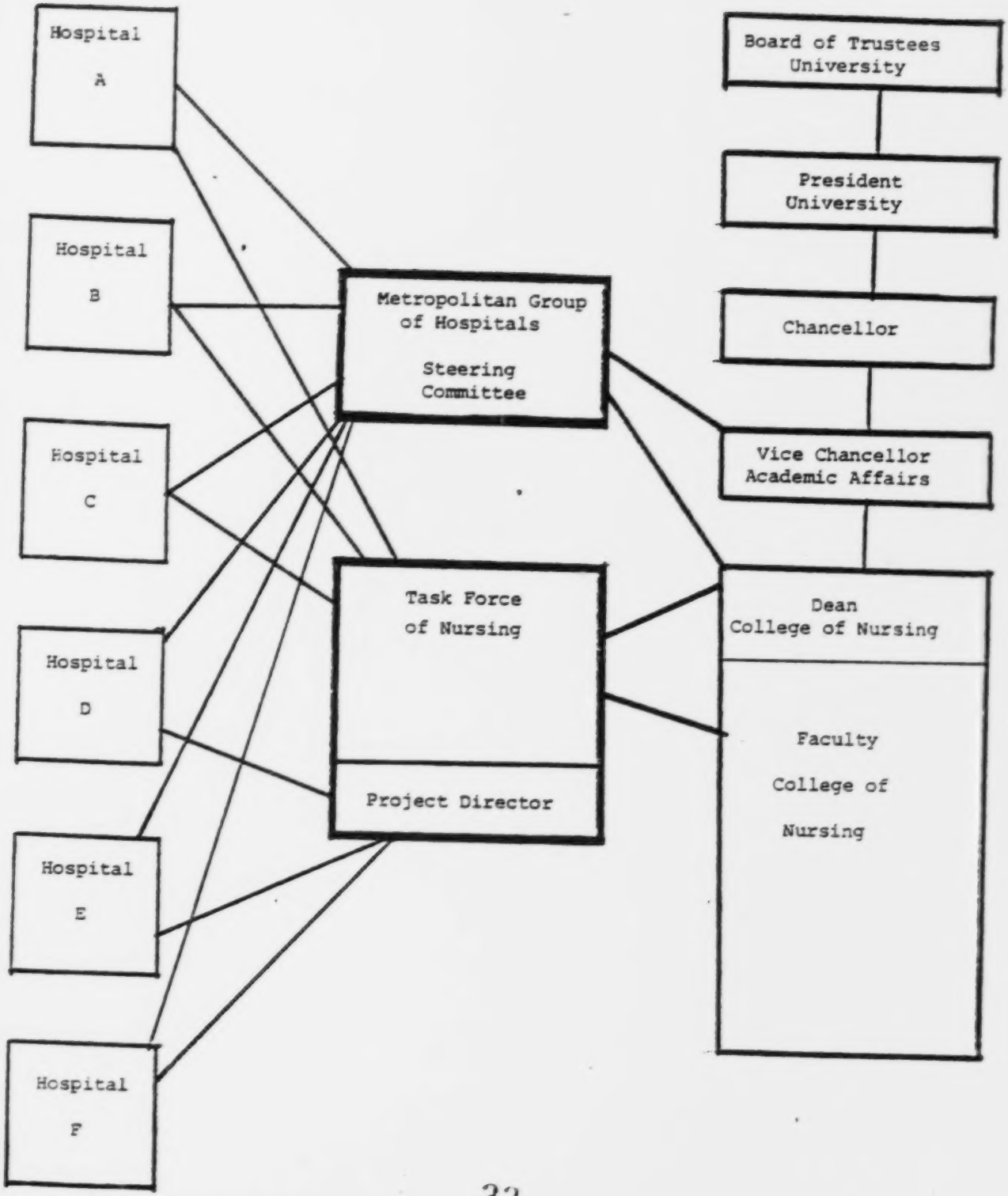
4. To develop a continuing education network.

In exchange, the participating hospitals within this affiliative agreement have responsibilities for accommodating the needs of the College of Nursing for its teaching programs. Use of hospital conference rooms and other learning resources is an integral part of this affiliative agreement.

In this process, the College of Nursing and the participating hospitals have become engaged in mutual exploration of ways of making transformations within the educational system, such as that of moving diploma schools of nursing into a generic baccalaureate program model, and developing an educational mobility system in concert with practice agencies. Within this model, hospitals who through the years have had an investment in nursing education, as evidenced in their diploma schools of nursing, are able to maintain a role as a major clinical site in the nursing education process, but in a model more appropriate to the education of nurses rather than their nonacademic training. As these discussions progress, and as the model builds, an integral component will be the building of joint faculty-practice roles throughout the system. Model VII illustrates the affiliative pattern. Provision for Community Health experiences are being addressed through the ambulatory care facilities of this hospital network, and through a similar affiliative process with the Chicago Board of Health.

MODEL VII

AFFILIATION MODEL



Independent Practice of Nursing Faculty

Within the current health care delivery system, severe limitations exist in research and practice opportunities for both faculty and students. All indications point to ambulatory care as being an important trend for the future, yet the opportunities for nurses to experiment and practice within this area are extremely limited. This, coupled with the potential role of nurses in the ambulatory care arena, necessitate the need for development of new practice settings appropriate for the research and educational needs of faculty and students. If nursing education is truly attending to its responsibility of generating and transmitting knowledge, it is important that nurse educators participate in the design of the practice settings of the future. One would wish that this might be a collaborative effort between medicine and nursing, but in some instances nursing is in an ideal position to take the lead. For example, home care of the dying patient, care of the elderly, and health education are areas in which nursing plays a natural leadership role. While there are some models of faculty practice emerging, the steps in this direction are sometimes tentative. The moving of faculty into a role of responsibility for care delivery is a giant step that needs a great deal of encouragement and support.

The University of Illinois is just beginning its experimentation with this model. Currently a nursing practice is being established within one of the rural areas served by an outreach program of the College of Nursing. Development of a nursing practice entails careful delineation of the scope of nursing practice that passes the scrutiny of legal counsel and that gains acceptance with the medical faculty who constitute the major referral source. Nurse faculty have taken responsibility for developing a schedule of fees for service, and have worked through all the systems of the university to evolve the fiscal management for this practice. Work with third party payers is now being undertaken for reimbursement for nursing services offered. This has required tremendous commitment on the part of faculty for work not usually considered part of their role. But the payoff in terms of learning experiences for students has been well worth the investment.

Summary

Unification, reunification, reconciliation, collaboration--these terms all reflect a heightened concern for closer working relations between educational programs and practice settings, between nursing faculty, and nursing staff. The history of nursing reflects our initial total unification model in which nursing service and nurse training were one. In our attempts to bridge the service-education gap, it is important that we keep our history clearly in mind so that we accomplish a closer alliance between nursing practice and nursing education without sacrificing one at the expense of the other. Nursing education cannot remove itself from involvement with practice settings. Rather, preservation of quality nursing education is a primary goal that can best be addressed through a

new alignment between education and practice. This paper has described the unification models currently in existence and has proposed that while these models may not be appropriate to all settings, other alternatives need to be explored and tested. Collaborative, affiliative, and independent faculty practice models are proposed and briefly described. Nursing education has a responsibility not only for the here and now, but for shaping the practice of the future. Responsibility for this future is shared by those of us within both practice and education. If we continue to go our separate ways we are indeed vulnerable. United, we have the power to shape our destiny.

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AN EXPERIENCE IN COLLABORATION -

Demonstration of Specialist Practice and Research

in a Nursing Home, Including Outcomes

Geraldine Price, Chief, Division of Nursing, Ohio Department of Health

and

Peggy Gray, Instructor, School of Nursing, Ohio State University

Foreword

Nursing Director Price and Nursing Instructor Gray move in for a closer look at a collaboration project cosponsored by the Ohio State University School of Nursing. In particular, they examine a federal and state supported system of highly successful Nursing Home Area Training Centers. Interestingly enough it was soon discovered that successful though these centers were in preparing competent staff for the special care needs of nursing home residents, there were still problems of inconsistent application and utilization of new knowledge into the practice setting. The daily implementation of skills learned at the training centers could not be monitored by Training Center staff once the training was completed. Therefore, clinical leadership at the nursing facility itself was targeted for development. Taking the proposal through the minefield of hierarchal approvals required significant effort and political astuteness of the Nursing Director. Once having succeeded in gaining approval for a clinical specialist position in the nursing home, there remained for the nurse who assumed this new role the stressful business of implementing it, and living through the experience under the watchful eyes of superiors and coworkers. The rites of passage encountered by this clinical nurse specialist were confronted, and turned toward improved communication and care. Changed attitudes and perceptions of staff showed that custodial care can become rehabilitative, preventive care in the hands of a sensitive, perceptive, and knowledgeable change agent.

AN EXPERIENCE IN COLLABORATION -
Demonstration of Specialist Practice and Research in a Nursing Home, Including Outcomes

Geraldine Price, Chief, Division of Nursing, Ohio Department of Health

Introduction

Ohio Department of Health and The Ohio State University have a long history of cooperation in many endeavors, some formal and others informal. Both operate on behalf of the state, and both are located in the same city. Each has unique resources useful to the other, and have many common goals. Working together, however, depends on the inclination of people within agencies or institutions. Collaboration does not always happen as a natural phenomenon. It is people who make or break collaborative efforts.

The project discussed in this paper concerns the use of a clinical nurse specialist in a nursing home. This project illustrates collaboration is possible even among a state bureaucratic agency, a state education institution, and a proprietary nursing home. In looking back on the experience, the design for collaboration was based on desire, opportunity, compromise, trade-offs, and timing. The background and role of the Ohio Department of Health Division of Nursing will be described first; followed by the report of Mrs. Gray's experiences as a clinical nurse specialist in the demonstration project, and the process of including the nursing home in the collaborative effort.

Background

For the past several years the Ohio Department of Health Division of Nursing has concentrated on three major goals. Its traditional role has been the improvement and expansion of community health nursing, and that continues to be a priority. Consultation services are provided to local community health agencies and to correctional institutions. A second goal is the development and implementation of a state master plan for nursing. The third is the improvement of care in nursing homes. It is this latter goal that is the subject of these papers.

It seems as though no one disagrees with the need to improve care in nursing homes; however, methods and approaches to move forward are complex. Nursing within a state health department can make a contribution through involvement in training, research, and regulation. Orientation, renewal of outdated skills and continuing education are continually necessary because personnel working in nursing homes cannot put into practice knowledge and skill they do not possess. Direct care personnel all too often have little or no preparation for the kind of care the residents need. This includes registered nurses and licensed practical nurses as well as nurse aides and other auxiliary workers.

Research is essential because of the need to find more effective, efficient, and humane ways of delivering care in the nursing home setting. Studies of ways to apply what is already known are needed as much as studies to discover new approaches. Regulation is important because government does set standards for the protection of people. In Ohio, regulation through licensure and certification is a function of the Nursing Home Division. Training and research are functions of the Division of Nursing.

The clinical nurse specialist project grew out of our experience in conducting educational programs for nursing home personnel through what are called Nursing Home Area Training Centers. In 1973, the Division was funded through the DHHS Office of Long-Term Care to demonstrate the effect of training centers serving groups of nursing homes in selected geographic areas of the state. The project was designed to offer short-term courses for all types of personnel working in nursing homes: RNs, LPNs, nurse aides, housekeepers, administrators, dietary personnel, etc. After courses were taught, follow-up visits in the nursing homes were made to evaluate changes in practice and to give further assistance in application or utilization of the course content. The Nursing Home Area Training Center project has continued to grow, and we have, through the follow-up visits, documented improved practices in the facilities. Funds were sought to continue the five centers and to expand into more geographic areas of the state when the federal contract expired at the end of two years. The Ohio Commission on Aging and two Area Agencies on Aging were sources of funding as well as the Ohio Department of Health. As the number of training centers grew, their reputation grew. The training courses were viewed as practical, available, affordable, and responsive to needs identified by the nursing home personnel themselves. Documentation of program cost and outcomes was used as the basis for requesting a special state appropriation to fund the Centers. The Nursing Home Area Training Cengers are now a line item in the Health Department budget. As of September 1980 there are ten centers serving the over 1,000 nursing houes in Ohio, with roughly 73% of the facilities sending personnel to courses. Attendance reached over 10,000 this past year.

Early experience through the training centers provided evidence that personnel attending courses did improve care. Bowel and bladder training programs were established. Residents who had been confined to bed unnecessarily were ambulated. Questionable use of sedatives and tranquilizers was decreased. Better housekeeping procedures were used. Personnel orientation and evaluation programs were initiated. These and other changes were documented through observations and interviews in nursing homes.

There was also evidence that changes in practice which were initiated with enthusiasm and sustained over a period of weeks or even months did not get integrated into the ongoing operation of the facility with any consistency. Problems related to philosophy

of care and staff's application of knowledge on a daily basis were beyond the training capability of the Nursing Home Area Training Centers. The key to allowing, let alone promoting change, was the leadership in the facility; that is, the director of nursing and the nursing home administrator. The problem was how best to influence the leadership. Having clinical nurse specialists in nursing homes would certainly help.

Clinical specialist project. The Director of Health had been kept informed about the progress and problems related to the training centers. The Director supported the idea of the Health Department funding a project to demonstrate the effect of a clinical nurse specialist on care in a nursing home.

It was about this time that Peggy Gray came to my office to see about part-time employment. She had just completed her Master's degree at Ohio State University and was doing some additional work in physiology. We talked about a number of possibilities related to care of the elderly. Studying the role of the clinical nurse specialist in a nursing home was of interest to her.

With some assurance from the Director of Health that funding would be possible, I contacted Joanne Stevenson, Ph.D., Director of the Center for Nursing Research at Ohio State University School of Nursing, to see if we could work something out together. Dr. Stevenson was most enthusiastic. We collaborated on a short statement of scope of the proposed work. It included:

Purpose: to describe what effect a clinical nurse specialist working in a nursing home can have on the care of patients.

Expected Outcomes:

1. A description of the development of a clinical specialist's position during one year in a selected nursing home, using an evaluation model.

2. Measurement of selected patients' progress during the 12-month period.

3. Measurement of the staff's attitudes and practices at designated intervals.

4. Measurement of the impact on the nursing home staff and the resulting changes.

Methods: The person appointed to conduct the study will:

1. develop the study design in collaboration with a faculty member.

2. select a nursing home agreeable to participate in the study.

3. work in the nursing home, developing the position of a clinical nurse specialist in line with study design.

4. submit report to Ohio Department of Health, Division of Nursing, suitable for distribution to nursing homes in Ohio.

The last point was of special concern. The report must be one that could be used with directors and administrators in nursing homes, and it had to be written in their language.

Once the scope of work was agreed upon, Dr. Stevenson negotiated through the director of the School of Nursing and the Committee for Research and Evaluation of Research Proposals at the College. Negotiating for the Ohio Department of Health was done through the Director of Health and his fiscal officer. Both the School and the Health Department negotiated the agreement with a nursing home as the setting for the study. Contracts were written and signed covering the following commitments:

1. The Ohio State University School of Nursing would conduct a study in accordance with the scope of work.

2. Ohio Department of Health would provide funds to cover the salary and fringes for the clinical nurse specialist over a 12-month period.

3. Ohio Department of Health Division of Nursing would provide secretarial service for typing and duplicating forms and reports, and would purchase literature needed for the study that was not available in local libraries.

4. Ohio Department of Health Division of Nursing would reimburse Dr. Joanne Stevenson for consultation service related to the development and implementation of the research aspects of the project.

5. The nursing home administrator and director of nursing agreed to orient the clinical specialist to the nursing home, facilitate implementing the study, and have bi-weekly one-hour conferences with the clinical specialist.

As Chief, Division of Nursing of the Ohio Department of Health, my role was a combination of facilitator and monitor. Initiating and negotiating the contracts facilitated the project. Monitoring progress

was accomplished through regularly scheduled conferences. These conferences provided for the Division's need to be assured that funds were being used appropriately, and also provided the clinical nurse specialist support and consultation during the study. A note dictated after one conference between Mrs. Gray and me three months into the project illustrates the kinds of problems we discussed.

> She meets a great deal of resistance from staff who really don't trust her. She senses a lot of under-the-surface resistance. It goes so far that sometimes the staff think she is crazy for wanting to work with the incontinent patients and the confused patients. She has noticed that people get most concerned about such things as whether or not she is wearing a cap or whether she does things as they have always been done. We talked quite a bit about what she is learning about the staff as people and explored ways of getting to know people while remaining non-judgmental about their behavior. I think Peggy wants to get everything into a theoretical framework fast, and much of her language could be turning off the staff.

Before Mrs. Gray describes what happened in the nursing home, I would like to share with you an attempt at collaboration that was not successful. The question of relationship between incontinence and use of sedatives and tranquilizers are of special interest to nurses working in nursing homes. One year ago a Ph.D. candidate at Case Western Reserve University and one of our Nursing Home Area Training Center coordinators outlined an approach to study the problem. The three of us talked, wrote back and forth, and finally came up with what we thought was a sound pilot study. Administrators and directors of nursing in several nursing homes were most enthusiastic and cooperative. They wanted to participate. Again, the Director of Health saw value in the study and authorized funds to get the project started. The methodology included an audit of patient records to determine the amount of medication given and the degree of incontinence in a selected patient population. Although we had developed procedures to obtain authorization by the administrators for review of patient records, it was brought to our attention that the law defining the Nursing Home Patients' Bill of Rights, requires each patient to authorize access to his record by anyone not employed by the nursing home or not performing a licensing or certification function. Study personnel were in neither of these categories. Our plan did not allow for the time required to get individual patient authorization, and we questioned how many patients in the defined population could really give informed consent. While this project had to be halted midstream, it is still in the right hand drawer ready to get some revision and a new start.

In summary, the Ohio Department of Health Division of Nursing has as one of its goals improving care in nursing homes and views education and research as essential to achieving the goal. Collaboration, joining with others having similar aspirations, is essential in moving toward our goal.

The Kalisch's in their article "The Politics of Nursing" (1976, p. 33) put into words so well what is needed.

> The art of advancing nursing depends upon people, timing, and events; personalities, luck, and knowhow are as important as the rules and regulations. Opportunism, compromise, trade-offs, and timing are not necessary evils, but the basic and legitimate principles of operation.

The collaborative experience we describe did have the elements of opportunity, compromise, trade-offs, and timing. Mrs. Gray was available and the Health Department had some unexpended funds. The amount of money was not enough to do a comparative study but could support a single demonstration project. The Division of Nursing absorbed the secretarial service and duplicated and distributed reports. Ohio State University School of Nursing faculty added to their research and publications, and the Division of Nursing received a useful report which was distributed to nursing homes.

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AN EXPERIENCE IN COLLABORATION -
Demonstration of Specialist Practice and Research in a Nursing Home, Including Outcomes

Peggy Gray, Instructor, School of Nursing, Ohio State University

The purpose of this presentation is to describe my role as clinical nurse specialist in the collaborative project to provide staff development and clinical demonstration of specialized patient care in a nursing home. The following topics are discussed in sequence:

1. How the nursing home was selected,
2. Negotiations with the home,
3. Orientation and identification of areas needing change,
4. Impact of the position on the system,
5. Change tactics used, and
6. Outcomes of the study.

The major resource for this paper is a log in which I recorded daily events including significant conversations. Other resources include various authors on conflict, collaboration, and change strategies.

Selection of Nursing Home

Eight sites were recommended by the Ohio Department of Health Division of Nursing Homes as agencies that were good homes and that might agree to act as a study site. I contacted and visited the proposed sites meeting with administration to describe the purpose of the study. Most had never heard of the clinical specialist position. However, six homes agreed to participate. From these, a 200-bed proprietary home was selected due to its population characteristics. Sufficient size was a factor because results could be generalized more easily from a large to a small home. Resident population in this home was more representative of the general public; for example, residents ranged from former housewives, teachers, and clerks to former farmers. Several excellent philanthropic homes perhaps would have been more supportive of the project as they were acquainted with the position, clinical specialist, and were eager to try it. However, the study site was chosen because it was more representative of the average nursing home. None of the staff at the study site had heard of the clinical nurse specialist position.

Thus, several issues were identified prior to entering the nursing home. First, the purpose of the project was to develop the position; therefore, I was not certain about how I would function in the nursing home. I was able to describe the ways in which clinical specialists typically function and I was able to describe how this position might be applied in a nursing home by citing typical issues for most nursing

homes, i.e., a need for work with confused residents, decreasing incontinence, etc. Bennis (1969) stated the affected system is more resistant to change when the outcome is not well defined (Bennis, 1969, p. 77). Resistance was anticipated because we could not clearly outline the predicted effects of this project on the system.

Next, because the staff had not heard of the position, another issue was clearly identified. The need for a clinical specialist was not defined by anyone representing the nursing home; instead, it was defined by the supporting organizations. Gordon (1973) stated that nursing administration in the clinical setting must identify a need for the clinical specialist in order to develop a strong commitment for providing support for such a project (Gordon, 1973, p. 205). It was therefore likely that there would be no strong commitment by this group since they had merely agreed to provide the site.

These issues demonstrate that while there was collaboration between the Ohio Department of Health and Ohio State in developing this project, there was initially a lack of collaboration between these organizations and the nursing home. While the relationship did contain some aspects of collaboration; for example, the relationship was voluntary and either agency could terminate the project; one very important aspect as missing; that is, the mutual determination of goals. The nursing home administration and the supporting organizations did share the goal of improving patient care; however, this was not mutually defined and it later became apparent that the support organization and the study site had different ideas about the meaning of improved patient care. Thus, true collaboration was lacking. To address this problem, one objective of the study was to provide information to all staff members about therapeutic nursing care of the aged so that staff could begin to value these interventions, thus leading to better collaboration. Because resistance was anticipated, change strategies were significant in development of the study.

After negotiation with the nursing home administration, I began a two-week orientation. I learned that the nurse's work included making assignments for aides, charting, and writing care plans which the caregivers (the aides) did not read. Staff nurses spent most of their time giving medications. Each unit had 50 residents and giving medications to this many people left little time for other nursing care. However, I noted that when there was extra time, the nurses were not able to use it constructively; instead, they might clean the station or the dayroom on the unit.

As in most nursing homes, the aides were responsible for nursing care. They bathed residents, dressed them, placed them in chairs, and served trays or fed them. The prevalent pattern appeared to be custodial care in contrast to rehabilitative or preventative care. For example, if a resident dressed slowly, the aides found it quicker

to use a wheelchair. They did not appear to consider the long-term effects of such interventions. One other major problem noted was a pattern of incontinence prevalent in the nursing home. Most confused residents were incontinent. Residents were not toileted unless they asked and even after asking were, at times, incontinent before receiving assistance. Many residents who were continent on admission became incontinent within a few days. The paradox presented was that the aides were so busy changing diapers and linens that they had no time to take residents to the toilet. Aides were very conscientious about changing wet linens as was evidenced by the minimal numbers of decubiti found in the resident population. Priority tasks appeared to be keeping the residents fed and clean, and keeping the unit clean.

The staff seemed to need assistance in redefining goals and using time in a more productive way, i.e., therapeutic rehabilitative and preventive care could be substituted for custodial care.

Patterns of Communication

Patterns of communication were observed during the orientation period that were typical of several nursing homes I had observed. The mode of communication between staff and resident was dependent upon the resident's status. If the resident was alert staff tended to patronize him, but at the same time held him accountable for his acts. Anger toward alert residents was not expressed in a direct way, but, instead, was vented through means such as ignoring the call light or using a hostile tone of voice.

Confused residents on the other hand were treated as small children. For example, they were mothered, hugged, and talked about as if they were not present. Most staff did not become angry with confused residents, based on the analogy that one doesn't become angry with a small child because he is not responsible for his acts. Those few staff that did show anger at confused residents tended to express it covertly by translating it into derisive humor, i.e., using humor to degrade, laughing at the resident, and using unnecessary controls. I observed few attempts at therapeutic interaction between staff and resident. Most verbal interaction took place during morning care and focused on physiological needs, such as "How was breakfast?" These conversations were fragmented, ending abruptly when care was completed.

Communication between residents was also typical of many nursing homes. Residents who were oriented refused to associate with confused residents. They ignored the confused residents and, at times, ridiculed them. The confused residents, while ostracized by others, did not tend to group; instead, they tended to ignore each other so that they rarely talked to other residents. Their need for socialization was demonstrated by constant attempts to talk with any staff or visitors. The staff made few attempts to change these patterns. Confused residents were usually not included in most activities because, as the director of nursing stated, "They would not remember it anyway."

Another issue identified during orientation was the relations between staff and families. There was a group of "problem" families who periodically exploded at staff. There appeared to be no route to work through and terminate issues; instead, the same issues continually reoccurred. The administrator did assist the families by listening; however, the nursing staff was more defensive. For example, one family member related that when she stated her concern about her mother's refusal to eat, she was told, "Why do you come here and try to force her to eat? She's 86 and its time for her to die!" There was a need to improve communications between family and staff. Also, I saw a need to work with families in crisis.

In addition to observation, one other purpose during orientation was to talk with all staff members and explain that while the role of the clinical specialist in a nursing home was not defined, one objective would be those nursing tasks staff felt were important but did not have time to accomplish. Staff were asked to list nursing tasks they would like the clinical specialist to perform. Responses were varied. The administrator asked for assistance with one family who required a great deal of his time. The director and assistant director of nursing were unable to define any specific work other than to say they were sure "things can be done in a better way". Several nurses were openly hostile and said there was no reason for the clinician to be in the nursing home; thus, change to them appeared to be a threat. Others responded in a more positive manner, but, again, other than suggesting the clinician hold clinical conferences could not identify any tasks. No aides were able to identify work. They did identify certain residents they disliked and asked the clinician to "do something about them". Although staff were unable to define many tasks, the orientation had identified many areas for change. Watzlawick, Weakland, and Fisch (1974) stated that often the attempted solution to a problem was to deny that there was a problem (Watzlawick, Weakland, & Fisch, 1974, p. 40). Many members responded this way to issues that were discussed. For example, when I stated I wanted to increase a resident's independence in eating, several nurses stated, "The aides are already doing that." The authors mentioned above also identify that the person who sees the problem is labeled as "mad" or "bad" by the group, and "denial of problems and attacks on those who point them out go together" (Watzlawick, Weakland, & Fisch, 1974, p. 40). This second postulation of these authors seemed also to apply to the situation. When I first entered the nursing home, reception was open and most staff were willing to talk about the home and their work. Once I began to identify some objectives, for example, establishing group therapy for selected confused residents, I noted avoidance behaviors by many staff members; for example, being too busy to talk or leaving the room when I entered. I allowed myself to become anxious and no longer used appropriate change strategies. Instead, as it became obvious the nursing staff did not want me there; I developed a strong "need to be needed" attempting to prove my worth to the nursing staff. I began providing answers in order to assist staff. This approach as documented by Hatton (1973) met with resistance and when a problem emerged, not only did the staff need to determine a solution, but also they needed to identify an alternative to those I had proposed (Hatton, 1973, p. 252).

Relations did not improve. Rumors circulated; for example, "The clinician had forced three aides to walk a patient and hurt their backs." The patient in question was a 200-pound man, hemiplegic following a stroke. The aides were lifting him from bed to chair, and I taught them to assist him to pivot. Meetings with administration continued and, in addition, they suggested weekly sessions with the nursing staff to improve communications. These meetings with the nurses were very helpful in improving communication and providing a route for group teaching; however, at first, they were very painful experiences as the first meeting was a verbal barrage by many nurses. The project plans were devalued; for example, walking patients, etc.; increasing activity was physical therapy's responsibility; working with confused patients was useless, but if anyone were to do this, it was the activity therapy department. One nurse stated, "It would be nice if we could get everyone up, walking, bathing, and feeding themselves." This last statement demonstrates Weakland's illusion of alternatives (Watzlawick, Weakland, & Fisch, 1974, p. 90)--either it is or it isn't, with no in betweens. Thus, if it was not possible for all patients to walk, bathe, and feed themselves, no intervention should be attempted.

Encouraging staff to express their anger was helpful. It was also evident that an evaluation of interventions was needed. Two issues emerged from the evaluation: (1) By identifying a need for change, I was stating there was a problem with present modes of care and, thus, staff had a right to be angry and I should expect these feelings as a normal response to the project in contrast to personalizing the anger; and (2) Next, I began to realize that what I was, a clinical specialist, while accepted in some areas of nursing, was unknown to this staff. What I was and how I functioned was really something outside of their experience. Instead of telling staff what a clinical specialist could do to improve care, I would need to show them, do it, and make this position a part of their experience. While some nurses continued to be uncomfortable with the changes, some became more positive and others were very supportive of the project.

As I said, meetings with nursing staff provided opportunity for interaction. After venting feelings, subsequent meetings focused more on presenting current theories about work with the aged. The next step was to present clinical problems and encourage staff to develop alternatives to deal with them. Other strategies involved flooding the units with relevant literature, inservice presentations, clinical conferences on the unit, and one-to-one work with staff. All this provided for more mutual development of goals and better collaboration. With collaboration, change was possible.

Work with Residents

Observations during the orientation period showed a lack of verbal interaction between confused residents. To improve communication, three resocialization groups were formed. Each group consisted of five to six confused residents. The purpose of these groups was to increase verbal

interaction among the group members. Method for group process was the sharing of pleasurable social experiences. For example, cookies might be baked by members and served in the group. Every fourth meeting of each group was simultaneously audiotaped and hand recorded by a non-participant observer. Verbals* between members did increase over a four-month period as shown in Table 1.

Table 1

Average Number of Verbals Member-to-Member or Member-to-Group Over Time (Analysis of Variance and T-Test Comparisons)

	Month I	Month II	Month III	Month IV	Sig. Levels
(ANOVA)					
Group A	7.4	18.2	18.4	27.0	$p < .0001$
Group B	4.2	9.0	7.5	11.4	$p < .0001$
Group C	1.0	5.8	20.2	38.0	$p < .0001$
(t-test) Before/After	5.0			25.6	$p < .0001$

Initially, members talked almost exclusively to the group leader (staff person). Since the focus of this part of the study was to observe changes in member-to-member interactions, member-to-leader verbals were not included in Table 1. Member-to-leader interactions showed no significant change over the four months of the experimental period. Leader-to-member and leader-to-group verbals were also omitted from this table. The number of verbals initiated by the group leader also did not change significantly over the four-month period. Table 1 shows only the average number of member-to-member or member-to-group interactions over the four-month period. The Analysis of Variance test on the four-month averages showed a significant increase at $p < .0001$ and the first to last month also showed a significant increase.

*Verbal: The term used to denote an oral communication initiated by a member of the group. The verbal was considered terminated when the member stopped speaking and did not begin again or when the speaker was interrupted by another person.

The fact that members did not talk to one another; but talked to the group leader appeared to reflect a devaluing of each for the other, i.e., no residents were friendly with confused residents. The group interacting and carrying out social rituals such as having coffee together seemed to allow these individuals to accept each other as fellow humans. Also, they seemed to relax more in each other's company. At first, there was very little sharing of self or laughing together. These two behaviors reappeared as the group progressed. One aide reported to me after a meeting that "I have never heard these people laugh like this; it makes me feel good to hear them." Other examples of behavior changes included members assisting other members in group activities, members checking to make sure everyone was served in contrast to a previous behavior of, at times, fighting over food. Members began to notice each other more; for example, giving each other compliments. Also, members often continued conversations with each other in the dayroom after meetings were over.

In addition to the resocialization groups, bladder continence training was initiated on one unit. Staff from all shifts were taught the major steps: increasing fluids and toileting on schedule. The unit staff selected four candidates. For five days prior to the study, they noted the number of times it was necessary to change sheets or clothes. After one month, staff again evaluated frequency of incontinence. Three residents completed the program.

Results show a decrease from incontinence of 87 times during the first evaluation to 23 times during the post-evaluation period. Most of these episodes were at night. Along with obvious benefits of this program, such as improved self-concept for residents and more focus on rehabilitation and preventive care for staff, there were other positive outcomes. For example, patients who had not left the nursing home in years could now be included in excursions. This program did not remain limited to the four original participants. Other nurses became interested and began working with residents on their own units.

The clinician in working with individual residents in the nursing home, focused on activities of daily living, helping residents to relearn how to feed themselves, how to dress, and how to maintain or improve

Table 2

Continence Training Results
Five Day Counts-Over 24 Hours

	Five Day Counts -- Average	Total	Over Twenty-Four Hours Total 8 p.m. - 7 a.m.
Before	27	87	46 (53%)
After	7.6	23	18 (78%)

their ability to ambulate. Ronney and Rothberg's "Activities of Daily Living Rating" (1963) was used to evaluate changes (Ronney and Rothberg, 1963). One resident who had been totally dependent in eating became totally independent. While this is certainly not possible for all residents being fed, it does demonstrate need for a continued evaluation and identification of needs.

Other areas of work with residents included helping them work through crisis and to use problem-solving techniques. One nurse requested that I see an individual who was very angry and in tears because she was moved from a two-bed room to a four-bed room. After allowing the resident to ventilate, I stated that granted the move had been made, could she think of anything that would make the move better for her? After thinking a few minutes, she stated that it would be better if she were by the window. I left her feeling somewhat depressed that she would not be allowed to return to her former room. Several days later, the nurse again approached and stated, "Mrs. P. has now calmed down, requested to be by the window, and says she likes this room better than the old one!" Incidents of this type seem to indicate that in a structured environment, such as a nursing home setting, even limited input is extremely important to residents in terms of decisions about self.

Work with Families as Part of the Nursing Home Project

I worked with groups of families and with individual families. Need for assistance was either determined by the staff or was requested by the family. One family referred by the staff was that of a young adolescent rendered almost unresponsive after a bout with encephalitis. The family visited every evening for several hours and during most visits confronted staff on the unit about the poor quality of care received. When confronted by the family in this manner, the staff responded angrily. Family and staff appeared to be at a standoff. After evaluating the resident, it was obvious the staff were giving good physical care. An assessment of the family revealed a group exhausted by their experiences in attempting to provide support for the resident. The mother worked full-time and every evening after work came with the family to the nursing home, staying until late evening with the resident. After this they returned home and the mother prepared supper while the children tried to catch up on homework. After encouraging the family to talk about the resident and express their feelings related to their loss, I encouraged them to talk about how this experience had affected them. Progress was noted when the mother stated that she had come in to see her son for the supper hour, but could not stay longer because the children needed to get home. Staff were pleased to see a steady decline in the number of critical outbursts from this family. After a conference with the staff, they were more understanding of this family's anguish. And, this in turn was reflected in their becoming more open with the mother, explaining more carefully how they were caring for him, and listening to her when she needed opportunities to air her feelings. As confidence in staff developed, their visiting time with the resident became more appropriate and better suited to this family's needs.

In addition to working with individual families, two family groups were formed. The purpose of these groups was 1) to teach some theory about successful aging, 2) to help family members understand goals and techniques of therapeutic care for their family member, and 3) to help participants deal with their own ambivalent feelings related to admitting a family member to the nursing home. Members were also asked to identify any additional concerns they wished to discuss in a group.

Nearly all concerns submitted by family members related to confusion and disorientation of the resident. Most were concerned about their own behavior; for example, whether their interactions helped or only made the resident more confused. After evaluating the group's process, the most useful techniques in group included role playing situations the members had experienced. For example, one member didn't know how to respond when her aunt asked to go home with her. Usually she replied, "Next time I'll take you with me." The relative was told to acknowledge the resident's statement, but then tell the truth. The relative practiced in group saying statements such as, "I understand that you want to go home with me, but this is where you live now."

Another important approach which evolved was discussing possibilities for therapeutic interventions each family member might use with the resident. For example, one family had never considered bringing in the resident's glasses because they believed she was too confused to be able to use them, and in any case did not either recognize or talk to them. After bringing her glasses, this family was pleasantly surprised to see her once again smile at them and increase verbal interaction. One other issue important in family group was to work with feelings of anger and ambivalence about having the family member in the nursing home. The second group had made steps with this issue when the project terminated, but in planning future groups this might be a priority goal.

To measure outcomes of the second family group, rooms were assessed pre and post group for presence of support devices and other familiar belongings from home. Providing these items would indicate some application of strategies discussed in the group. Table 3 demonstrates items families brought in. Another outcome noted was families who had met for the first time in the group congregated when visiting, apparently forming a support group for each other.

Another by-product of the family group was the development of an orientation pamphlet for the nursing home. The idea for this pamphlet originated from the family groups. The members pointed out that no written information about the nursing home was available to families of new residents. Using information suggested by these families, a pamphlet was developed which included a map of the interior of the nursing home, a listing of services available, and articles that should be brought from home such as clocks and calendars.

Table 3

Orienting and Personal Items Brought to Residents by Families

Residents	Time	Date	Family	Sensory Aids	Other
1	Clock	Calendar	Family Photos		Houseplants
2		Calendar			
3		Calendar	Family Photos		
4		Calendar	Family Photos	Eyeglasses	
5	----Radio-----			Eyeglasses Radio	Quilt
6	----Television----			Television	Afghan

Outcomes for Staff

Once the staff and I became acquainted and I was able to teach current theories about innovations in nursing care for the aged, some staff did share values and goals. Collaboration was possible and changed did occur. I worked one-to-one with staff on the unit via role modeling and teaching. For example, I used therapeutic interactions with confused residents and then discussed my purpose with any staff present. Weekly meetings with the nurses continued. Discussion usually dealt with some problems on the units. These varied from how to deal with a newly admitted resident with massive decubitus ulcers to assisting a confused resident to remember her assigned room and bed.

I also held clinical conferences on the units and, at times, interjected approaches unique to the nursing home. Just as I was collaborating with staff, I began teaching staff to collaborate more with residents. For example, one resident was at odds with staff because she had a prolapsed bladder and needed frequent toileting. The approach to this problem had been simply to tell staff without explanation they must toilet the resident on demand. Their response had been to ignore her light for long periods during which she called loudly for the aides. Aides did not enter her room unless it was required and left as soon as possible. The resident was aware the staff were angry and she cried about the anger and isolation, but did not know how to improve matters. A conference with the aides about prolapsed bladder and possible interventions led to remarks such as "She isn't doing this just to be mean." The conference was then moved to the resident's room where the aides discussed their anger at the resident's

screaming and the resident talked about how painful it was to wait. The aides developed interventions such as increasing fluids and checking with the resident about when she needed to void. The resident agreed to help and to stop screaming at the aides. One nurse worked with the staff and resident to increase fluids and, as a esult, the resident's bladder spasms decreased significantly. She had been getting injections for pain and no longer needed these. Numbers of toileting times decreased. More importantly, the resident no longer was alienated from the staff. Another type of response was shown by a nurse who watched me ambulate a resident, then waved all the aides over, saying, "Let's all take someone for a walk." This was in contrast to the earlier statement that ambulating was PT's responsibility. Also, several nurses began looking more closely at effects of drugs on residents. They decreased doses of tranquilizers in a small study and were able to maintain lower dosages for some residents.

While descriptive reports are useful, it is also important to identify a measure of impact on staff. This was done by completing a ten-day count of the number of nonambulatory residents taken to dayrooms pre- and post-study. It was believed that if aides were assisting more residents to the dayrooms, this would indicate a greater value of environmental stimulation. The results of this count are included in Table 4. The three dayrooms surveyed represented the three units in which residents were least able to ambulate. Unit 1 was excluded because the residents were generally ambulatory or independently able to propel themselves in a wheelchair. Only nonambulatory residents who could not walk or propel themselves independently in a wheelchair were counted. These residents depended on the aides or nurses to assist them to the dayrooms.

Table 4

Comparison of Ten-Day Total Counts of Nonambulatory Residents in Dayrooms Early and Late in Project

	Unit II	Unit III	Unit IV	X^2
Early in Project	78	112	87	
Late in Project	134	153	93	* p= <.01

*All three groups

Chi square was computed to test for differences between expected and observed numbers of residents in the dayrooms early and late in the project. The increase in each case was statistically significant, although one can see that Unit IV did not appreciably increase the number of residents going to the dayroom.

The outcomes discussed were those evident at the end of the study in 1975. In 1980, I made a five-year follow-up visit to the same nursing home and these are several outcomes I noted continuing today: The socialization groups are intact. The incontinence program grew from a small study to include all units. The home no longer has a urine smell typical of many nursing homes. The home requested assistance from the local mental health center to develop another family group. Staff requested assistance from the Lions Club in a project to examine eyes of all residents. The home now has an advisory board made up of professionals from nursing, occupational therapy, physical therapy, and dietary. This board now meets each month to evaluate residents and their changing needs.

The positive outcome of this study demonstrates the impact of collaboration on groups of people working together for goal achievement. At first, conflict over the definition of "what constitutes good patient care" interfered with implementation of the project. Once a common knowledge base was established, the nursing home staff and the clinician were able to collaborate, resulting in more rehabilitative approaches to patient care.

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SECTION III

EXPERIENCE IN COLLABORATION - USING THREE METHODS

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Foreword

Dean Rosalie Klein of Marquette University and Executive Director Mary Jane Mayer of the Milwaukee Visiting Nurses' Association bring into clear view the working relationship of a community health nursing agency and nursing educational programs when students are placed in the agency for guided basic experience. A 49 percent to 51 percent University to Agency joint appointment was arranged with primary employment at the service agency, and a Master's prepared nurse was appointed to fill the position.

The effect of having an agency-based clinical specialist, who knew the Community Health Nursing course content and whose role included management of the students' learning experiences allowed much more appropriate utilization of the other agency staff. Other chronic problems related to organization of learning experiences were significantly reduced.

Establishing and fulfilling a formal preceptorship program has brought as many significant benefits to the agency as to the student. The directors of hospital nursing services, community health agencies, nursing homes, and directors of nursing educational programs in the Milwaukee area have formed an association to work toward resolution of issues of mutual concern. Thus, we see effective multi-faceted collaboration achieved at three levels: the level of the individual through joint appointment; the level of small groups through the preceptorship program; and the level of large systems through the service-educational organization.

EXPERIENCE IN COLLABORATION

Joint Appointments for Nursing Education - Nursing Service

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Introduction

During the past five years formalized collaborative appointments have been studied, designed, and initiated at Marquette University College of Nursing. The various stages of development of joint appointments, courtesy appointments, and preceptorships with non-university hospitals and health care settings will be described.

Joint appointments as designed today are suitable only for a very special group of professionals. Not everyone can assume such a role. The position is frequently sought by professionals who are intellectually challenged to seek new knowledge not only through library resources but through experiences gained as practitioners in the clinical setting. These practitioner-teachers are unique individuals who have a great deal of courage. They are committed to teaching and to patient care serving also as change agents and risk takers. These practitioner-teachers are also capable of setting realistic parameters for teaching, research, and service.

Joint Appointments Established at Marquette University

In 1975, several faculty of Marquette University College of Nursing began to search for ways to create joint appointments. By 1976 the faculty formalized a broad position description which since has been revised and serves as a guide for all joint appointments. The position as defined is held by a nurse faculty member who also holds an appointment in a hospital or health care agency. The appointee has responsibility for both nursing education and nursing service.

The primary appointment may be with the College of Nursing or with the service agency. The percentages of time committed to both are mutually agreed upon by the Director of Nursing Service and by the Dean of the educational program in collaboration with the faculty member involved.

Since the primary appointment may be either with the University or the health care agency, the academic rank of the faculty member is consistent with Marquette University's policy. Faculty who have their primary appointment with the University hold the rank of Instructor, Assistant Professor, Associate Professor, or Professor. Those who have their primary appointment with the agency have "Adjunct" added to their rank. Requirements for promotion in academic rank in either type of joint appointment is based on teaching excellence, scholarly activity, research, and service to the College, University, and the community.

Qualifications and Responsibilities of the Joint Appointment Position

Faculty wishing to pursue a joint appointment follow the same appointment procedure that is outlined for other Colleges or Schools within the University. The College of Nursing faculty have identified seven qualifications essential for any type of joint appointment. These include:

- a minimum of a Master's degree in Nursing
- knowledge of the teaching-learning process
- a minimum of one-year's experience as a practitioner or administrator at the Master's level
- ability to serve as a role model in a practice setting
- ability to foster a climate for practice, education, and research
- knowledge of the research process
- demonstrated creative ability

The major responsibilities of a faculty member in a joint appointment were also identified and agreed upon by faculty. These include the following:

- collaborates with faculty in the clinical practicum and/or classroom teaching
- facilitates student learning in a clinical setting
- serves as a role model for students
- attends College of Nursing monthly faculty meetings and other meetings as indicated
- works with a specific patient/staff population
- participates in research

Benefits for Joint Appointees

Faculty benefits available to all full-time faculty at Marquette University are available to those faculty who have their primary appointment with the University. While those who have their primary responsibility with the Health Agency have benefits approved by the agency as well as those approved for part-time faculty at the University. The cost of fringe benefits are shared by the two employers according to the actual time spent in each position. These fringe benefits are determined on an individual basis for each joint appointment. Since the percentage of time

varies with each individual, the salary and fringe benefits are determined by the Personnel Director of the Agency, Dean of the College of Nursing and the Director of Nursing Services at the particular agency. It is significant to note that all faculty at Marquette University hold ten-month contracts while health agencies usually have 12-month contracts. These differences in types and duration of contracts make it difficult at times to determine the exact equalization of faculty salaries and fringe benefits.

All faculty in joint appointments receive a Marquette University identification card which is their key to campus service. Upon receiving the card it is validated with the individual's signature. It is honored for one calendar year. Through this card, the faculty is identified as an employee of Marquette University and is enabled to:

-realize tuition benefits at Registration as provided under present University policy.

-utilize the services and facilities of the Memorial Library

-participate in campus functions and receive services which may be restricted to University employees

-obtain a 10% discount on purchases from the Marquette University Bookstore, (certain items may be exempt from this discount)

-cash personal checks at the Bursar's Office

-obtain a 10% discount on charges made for work performed at Marquette University Dental Clinic.

An important benefit Marquette University extends to its personnel is the opportunity to take credit and non-credit courses on a free tuition basis. This benefit applies to all faculty who hold joint appointments. Faculty and their wives or husbands may each take six credits per semester and the Summer Session on a free tuition basis, as long as the faculty member remains on contract with the University. The six free credit hours can be taken in either graduate or undergraduate courses or any combination thereof. An individual may enroll in continuing education programs in addition to or as an alternative to taking credit courses; the free tuition allowance available for continuing education programs will equal the unused credit hours computed per credit hour tuition rate.

Individualization of Joint Appointments - Courtesy Appointments

Since the joint appointments at Marquette University College of Nursing are individualized, samples of these types of agreements are presented in the appended reference.

In 1976 the faculty of the College of Nursing developed a position description for courtesy appointments. The initial appointment is for a one-year period. The courtesy appointment is reviewed on an annual basis and reappointments are made annually. This position is held by selected individuals who do not hold regular appointments at Marquette University, but who either participate in the educational program of the College of Nursing in a limited way, or whose competencies and responsibilities place them in positions to influence significantly the educational and research programs of the College of Nursing. Generally, no fee is paid to these individuals for such participation in the educational program. These appointees receive the rank of Courtesy Instructor, Courtesy Assistant Professor, Courtesy Associate Professor, or Courtesy Professor. Promotion in rank is also established according to University policy. The four major qualifications for this type of appointment include:

- educational preparation for the rank of the apointment
- demonstrated expertise in a field of endeavor related to nursing or health disciplines
- interest in and ability for teaching
- and significant influence upon the climate for practice, education, and research.

The responsibilities of a faculty member holding a Courtesy Appointment are limited to education, research, and service contributions. The individuals are invited to relevant College of Nursing Committee meetings, workshops, and seminars. The benefits received include recognition through listing in the University catalog; participation in academic and social events of the College of Nursing and the University; the use of Instructional Media Laboratories and Libraries; faculty discount at the Marquette University Bookstore; and use of the Helfaer Recreation Center on a faculty fee paid basis.

Courtesy appointments are open to both nurses and non-nurses. Examples of professionals who could receive these types of appointments include:

- a dietitian, physician, physical therapist or nurse specialist who regularly teach a few hours of class as a guest lecturer each semester
- a staff nurse or head nurse employed in a service agency who orients and guides students rotating through special departments, such as Emergency Room, Intensive Care Units, or Operating Room
- a Director or Associate Director of Nursing Service who play a significant role in facilitating educational experiences or in creating a climate for learning or research

- a nurse faculty member of another institution who regularly acts as a preceptor for a graduate student's teaching practicum

The appointment process is similar to appointment of new faculty at Marquette University.

Special Recognition of Preceptors

During the past year, faculty and administration of the College of Nursing felt it necessary to recognize preceptors who assisted with the educational process. Since preceptors are needed for students in the graduate program for practice teaching, and eventually for the undergraduate students enrolled in a synthesis course, it was felt that some type of recognition should be given to the preceptors.

A policy was initiated by which all preceptors receive the Marquette University Identification Card after their curriculum vitae has been carefully reviewed and the individual meets the qualifications necessary to be a preceptor at the College. It should be noted that all preceptors are responsible to a full-time faculty member appointed by the University. At present, some of the benefits enable the preceptor to:

- utilize the services and facilities of the Marquette University Libraries
- obtain a 10% discount on purchases at the Marquette University Bookstore
- obtain a 10% discount on charges made for work performed by the Marquette Dental Clinic
- participate in campus functions by specific invitation
- attend College of Nursing Colloquia.

The preceptorship is awarded on an annual basis. The preceptor must be actively engaged in activities relating to a specific course either in teaching on a graduate level or assisting with the supervision of undergraduate students in the selective nursing synthesis. This type of formal appointment will be evaluated on a regular basis and a detailed position description will be developed during the coming year.

As mentioned earlier, all three types of appointments in a University associated with numerous clinical facilities require a commitment of time and energy on the part of administration, regular faculty, and the appointee. Collaboration and coordination are essential for the success of these endeavors.

JOINT APPOINTMENT

Position: JOINT APPOINTMENT
Initial appointment for one year - reappointment annually

Description:

The position held by a nurse faculty member who holds an appointment in a hospital or health care agency. The appointee has responsibility for both nursing education and nursing service. The primary appointment may be with the College of Nursing or the service agency. The percentage of time committed to both will be mutually agreed upon by the Director of Nursing Service and the Dean of the educational program in collaboration with the faculty member involved.

Rank:

Primary Appointment to the College
Instructor, Assistant Professor,
Associate Professor, Professor
(Promotion in rank according to University policy)

Primary Appointment to the Hospital or Health Care Agency
Clinical Instructor, Assistant Clinical Professor,
Associate Clinical Professor, Clinical Professor
(Promotion in rank according to University policy)

Qualifications:

1. Minumum of a Master's Degree in Nursing
2. Knowledge of the teaching-learning process
3. Minimum of one year's experience as a practitioner or administrator at Master's level
4. Role model in a practice setting
5. Significantly influences a climate for practice, education, and research
6. Knowledge of the research process
7. Demonstrates creativity

Responsibilities:

1. Collaborates with faculty in clinical practicums and/or classroom teaching
2. Facilitates student learning in a clinical setting
3. Serves as a role model for students
4. Attends College of Nursing monthly faculty meetings and other meetings as indicated
5. Works with a specific patient/staff population
6. Participates in research
7. Serves as advisor for students' essay/thesis

Benefits for full-time faculty:

Full-time faculty in a joint appointment receive the same benefits as all full-time University faculty.

Benefits for part-time faculty:

1. Recognition through listing in the University catalog
2. Participation in academic and social events of the College of Nursing and University
3. Use of Instructional Media Laboratories and Libraries
4. Faculty discount at Marquette University Bookstore
5. Use of Helfaer Stadium (faculty pay basis)
6. Tuition remission as specified for part-time faculty (6 credit hours)

Examples of Such Appointments in Terms of Facilities and Time:*

1. Marquette University College of Nursing, 60%; Health Care Facility for the Aged, 40%
2. Marquette University College of Nursing, 70%; Hospital, 30%
3. Neighborhood Health Clinic, 70%; Marquette University College of Nursing, 30%
4. Physician's Office, 75%; Marquette University College of Nursing, 25%

*Percentage of time will vary with the particular needs of the College and/or facility.

Cost of Fringe Benefits:

The cost of fringe benefits will be shared by the two employers according to the actual percentage of time spent in each position.

EXPERIENCE IN COLLABORATION

Nursing Education - Nursing Service

Mary Jane Mayer, Executive Director
Visiting Nurse Association of Milwaukee

Introduction

This discussion describes experiences in collaboration from the viewpoint of a community health agency; namely, the Visiting Nurse Association of Milwaukee through three methods of collaboration: (1) joint appointments, (2) preceptorships for graduate students, and (3) a community-wide meeting of nursing service directors and educators--the Greater Milwaukee Area Nursing Service and Nursing Educators--its acronym - G-MAN.

The Visiting Nurse Association of Milwaukee

First let me acquaint you with the clinical setting provided by the VNA to baccalaureate students. The VNA employs 100 staff nurses; 90 percent of whom hold a baccalaureate degree. Each nurse manages a caseload of 20 to 30 patients and is accountable for all of the care given. The nurse in turn is accountable to a field supervisor, who is responsible for the quality of the care in a given geographic area. The supervisor is accountable for 10 to 12 nurses. In addition, the VNA employs four clinical specialists (defined as masters prepared in a nursing specialty). We presently have four clinical specialists holding a Master's degree in Nursing of patients with rehabilitation needs, medical-surgical, chronic illness, and respiratory diseases. The clinical specialists have a dual function--consultation with VNA staff and direct patient care. Patients on the VNA caseload run the gamut from acutely ill patients with intensive care needs visited one or two times a day, to long-term care patients visited once or twice a week or perhaps once a month. We see families from single one-member families to extended families. A trend in our caseload is for more frequent visiting; increase in the use of after-hours evening services; increase in multi-problem families with social, health, and economic needs; and most especially, an increase in the intensive nature of patient needs requiring a high degree of technical skill.

The accountability for maintaining a relationship with the schools is the responsibility of the Director of Education. All problems and concerns of VNA staff regarding student programs are addressed to her. Likewise, the schools communicate to her regarding all administrative aspects of the program; scheduling, semester changes, numbers of students, names of students, etc. The supervisors in each area work with the faculty in case selection, identification of skill level of the student and the explanation of agency practices. Evaluation of the student's experience and the orientation of faculty are joint responsibilities of the Director of Education and the supervisor.

Adjunct Clinical Appointment - Planning Phase

This therefore sets the stage for clinical experience offered by the VNA to the baccalaureate student. In 1974 the University of Wisconsin-Milwaukee approached the VNA to discuss the possibility of an adjunct clinical appointment. The University was experiencing difficulty in recruiting prepared community health faculty. The VNA imposed faculty-student ratio of 1:8 was not cost-effective. The University also had a concern for the limitations on patient selection proposed by the VNA. The VNA in turn was concerned about faculty preparation, frequent changes in faculty, the sequence of time which the students were placed in the clinical setting, and the continuity of patient care when students were not available. Many of these concerns were addressed as we discussed the possibility of an adjunct clinical appointment. The University required that any clinical instructor have the following prerequisites: (1) master's prepared, and (2) three years of experience in community health nursing. The University was willing to compromise. They would accept a baccalaureate prepared staff nurse who had five years of experience in community health nursing if she worked under a master's prepared nurse in our agency. The VNA was concerned over the cost and care-effectiveness of the joint appointment. Initially, the VNA and the University of Wisconsin-Milwaukee arrived at a mutual conclusion that while the agreement for an adjunct clinical appointment would be between the individual employed by the VNA and the University, the individual would remain an employee of the VNA and would continue on the salary scale and fringe benefit level she was receiving at the VNA. The first adjunct appointment was initiated as a 30 percent salary and prorated benefits from the University of Wisconsin/70 percent from the VNA. The VNA felt that the appointment would be more than 30 percent of the person's time, but on a trial basis we began with the 30:70 ratio. After discussions with the University we shared their belief that a master's prepared person would be ideal. We happened to have available a master's prepared clinical specialist who had had teaching experience. She accepted the clinical appointment.

Effectiveness of the Clinical Adjunct Appointment Role

During the first year of the adjunct appointment, the VNA's clinical specialist attended all community health nursing courses. She was oriented to the University by the course chairman. She attended all community health faculty meetings. At the end of the first semester of the clinical specialist's adjunct appointment, the school, and the VNA met to evaluate the effectiveness. At that time we decided that it was effective from both the University's and the VNA's viewpoint. The VNA found it effective for several reasons:

1. Supervisory time spent on student and faculty orientation was reduced by 20 to 30 hours a semester.

2. Administrative functions such as billing, etc., were expedited without a great deal of agency or student time. The student

could concentrate more on learning experiences, less on office and billing procedures.

3. Case selection improved because supervisors knew the clinical specialist's skills and were freer in sharing cases.

4. Communication regarding what happened to patients between student visits was eased and more effective.

5. More frequent consultation with supportive staff (i.e., social worker, dietitian) occurred because the clinical specialist knew them, their skills and their schedules.

6. There was a lessened need for joint visits with VNA staff--the students therefore were carrying their own cases sooner.

7. The supervisor no longer had to make case management decisions; when students and faculty were not available, as the clinical specialist intervened.

8. The clinical specialist was able to facilitate communication between the students and PM nursing staff regarding changes in patient's condition occurring in the evening.

9. The clinical specialist was able to select cases where the VNA staff nurse and student shared a case. Discussions with VNA staff in preparation for our discussion today also revealed they felt they got to know the students better and joint conferences were mutually beneficial.

VNA Administrative Benefits

Evaluating the adjunct clinical appointment from an administrative point of view it: (1) released time for supervisors to spend in other duties; (2) provided the VNA an excellent opportunity for input into curriculum development; (3) assisted the VNA to see the viewpoint of the University and to understand more clearly their objectives and concerns; and (4) financially the 30% University/70% VNA ratio changed following a time study by the clinical specialist to 49% University/51% VNA. The VNA has made the decision to continue this way so that the majority of the clinical specialist's pay comes from the employing agency. Administration had been concerned that perhaps the clinical specialist would so enjoy teaching that she would be lost to the agency. This has not happened. Instead, her contacts with the University have enhanced her skills and thus her value to the VNA, and most importantly, her effectiveness in patient care.

The original adjunct clinical appointment with UWM continues today with the same person. In addition, we have had a second adjunct clinical appointment with Marquette University; again with a master's prepared clinical specialist.

Views of Other VNA Clinical Specialists

When interviewed, the clinical specialists saw the following assets to adjunct appointments: (1) students added a new dimension and an opportunity for them to share their knowledge; (2) the students seemed impressed by the fact the instructors were practicing nurses as well as teachers, and (3) they were able to demonstrate areas of nursing independence--occurring in the real world. As to problems--both clinical specialists felt use of time could become a problem. They felt the need to have complete flexibility in use of their time while they had teaching responsibilities. There were some concerns by VNA staff nurses when the clinical specialist was not available for consultation. The clinical specialist in turn found it difficult to say no to consultation requests. One of the clinical specialists had no teaching experience. She felt uncomfortable initially, but with guidance from the Director of Education she quickly overcome this problem and in fact is now participating in theory classes at the University.

Finally, all VNA staff involved enjoyed students. All of the supervisors questioned felt as comfortable with university faculty as they did with the adjunct clinical appointments given two constants of the university faculty--preparation and experience in community health and continuity (that is at the agency for more than one semester).

Preceptorships

A second form of joint collaboration is preceptorship for graduate students. Sister Rosalie Klein in the previous paper has described well what a preceptor is, therefore, I will describe VNA's experience. We have worked with graduate students in administration and chronic illness. The preceptor is determined by the course and student's objectives. The student, the course chairman, and the VNA agree on who becomes a preceptor. Once a preceptor is assigned she meets regularly with the student and at least twice a semester with the faculty member. The student works on a project that will meet her objectives and will serve a useful purpose for the agency. For example, I worked with a student in management who assisted the agency in initiating a peer group of clinical specialists. We have found many advantages to these preceptorships. From a personal point of view I found them to present a real challenge. The student brings her viewpoints, her ideas, her concerns, her philosophy of nursing, and the preceptor has a reciprocal opportunity to work with, teach, and learn from the student. The time that this takes provides new horizons, new ways of viewing things, and new literature. The student received practical management experience, an opportunity to speak and to share mutual philosophies. Preceptorships also offer an effective recruitment tool. One of the former graduate students now holds a top management position at the VNA.

Service-Education Organizational Collaboration

A third example of nursing service and education in collaboration is the Greater Milwaukee Nursing Service and Nursing Educators (G-MAN). This group represents directors of nursing in hospitals, community health agencies and selected nursing homes, and directors of the baccalaureate, diploma, and A.D. programs in the greater Milwaukee area. G-MAN meets every two months. The meetings produce lively discussion, conflict, and at times consensus. One of G-MAN's accomplishments has been the preparation of a position paper on the use of temporary manpower. The collaborative group is presently working on nursing competencies.

It is collaborations like the three listed above that will preserve nursing as a dynamic force in health care. Through these kinds of efforts and more, nursing will come to grips with what it was, what it has become, and what it must be in the future.

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SECTION IV

THE NEED FOR COLLABORATION -

A Statewide Nursing Consortium as a Facilitating Mechanism -

An Educator's Perspective

Elisabeth Zinser, Ph.D., Dean, School of Nursing
University of North Dakota

Perspectives of Nursing Service - A Personal Account
Beth Roder, Director of Nursing Services,
Cavalier County Memorial Hospital, Langdon, North Dakota

Transition from School to Practice
A New Graduate's Perspective
J. Jean Mellum, R.N.

Foreword

The final papers contain a triad of concentric views by an educator, a service director, and a new nurse graduate. These three focus their perceptions upon the three levels of collaborative implementation in reverse order from the previous presentation from organizational, to programmatic, to individual. Each is qualitatively very different yet unusually complementary to the whole. Whether the predominantly rural nature and geographic distances between agencies in North Dakota make the two factions of nursing service and nursing education more needful of one another's resources and hence more likely to collaborate than other service-education groups can only be conjectured. Nevertheless, the spirit of cooperation and collaboration is evident; the enthusiasm and taste for more development along the same shared paths are enviable.

THE NEED FOR COLLABORATION -

A Statewide Nursing Consortium as a Facilitating Mechanism -

An Educator's Perspective

Elisabeth Zinser, Ph.D., Dean, School of Nursing
University of North Dakota

Introduction

It is a privilege to be a member of the Midwest Alliance in Nursing; and speaking for all three of us, it is an honor to be asked to express our views and experiences in collaboration. We come from the North country, not as far from here as one's cognitive map of geography might imagine. In fact, you should know that North Dakota has the privilege of being the geographical center of the North American continent. Thus, we should now be situated in the center of your geographical mindset.

As the first of three presentations, this paper will provide a general view of the concept of collaboration, the relationship between education and society, the need for collaboration between nursing service and nursing education, and a description of the facilitating mechanism recently developed in North Dakota: The North Dakota Nursing Education Consortium.

Of course, these remarks will provide an educator's perspective. Beth Roder will offer the perspectives of nursing service; and Jean Mellum will express her views as a new graduate in that point of the curve of time which offers a balanced view backward through formal education and forward into nursing service.

The Nature of Collaboration

It is often helpful to return to simple definitions in the search for principles. Consider the term "Collaboration". It means to work together. Indeed, the word itself contains its primary meaning: "co-labor". The first two letters alone have inherent in them a key principle. "Co" - implies that there are two or more distinctly unique identities working together. For example, the word "cooperate" means to "operate" together for a common purpose and to share in the benefits or profits derived from that activity. To "coordinate" means to bring into proper order or to harmonize.

All three of these terms emphasize the interrelationship and interdependency between two or more separate and distinct entities. The implicit message is that in collaborating our goal is not toward uniformity or oneness, but rather toward close association and unity. Diversity and unity can co-exist. In fact, it is in our diversity that we find the tension necessary for creativity; and it is in unity that we achieve a balance toward oneness of purpose. The balance and the tension are necessary catalysts to bringing about the best uses of various systems in the interest of the troubled individual and communit

To seek uniformity would be both inappropriate and counterproductive; rather we seek collaboration as a symbiotic relationship--a close association between dissimilar parties, with advantages to both.

Each of the terms cited above emphasize a different aspect of that symbiosis. "Collaborative" emphasizes working together. "Cooperate" focuses upon commonality of purpose and shared benefits or profits. "Coordinate" speaks to the search for order or harmony in the relationship. A harmonious working association in the interest of a common purpose is, thus, the nature of collaboration.

Collaboration and the Health Care System (Figure 1)

There are three essential partners in the health delivery system: The educator, the practitioner, and the consumer. The symbiotic triad of roles of the public, educational institutions, and service agencies represents a relationship in collaboration. A balanced and interdependent relationship determines the health status and practices of society. Each has autonomous, as well as shared responsibilities. The autonomous responsibilities are as follows:

1. The public sets the standards of health by its knowledge and habits related to its well-being; and through public policy.

2. The service community of practitioners sets the standards of care.

3. The educational community sets the standards of teaching and research.

While each group is characterized individually by its autonomous responsibilities, mission, and particular competencies, a collaborative relationship enables each to gain alternative perspectives in exercising these responsibilities.

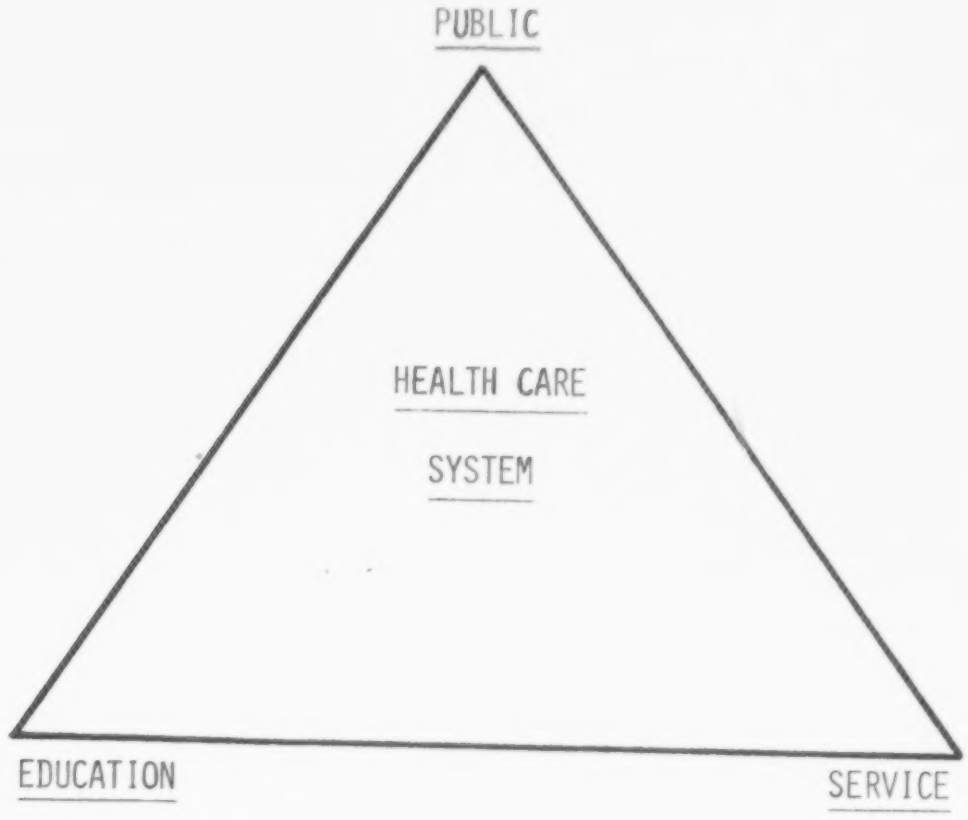
More importantly this collaborative triad shares responsibility for standards of practice in the actual operation of the health care system. Through such co-operation, the standards of health, education, and service can be achieved, enhancing the quality of life for all of us--each realizing the shared profit of the cooperative relationship.

Interrelationship between Education and Society

There is an inextricable relationship between the purpose of education and the nature of society. The concept of popular education dates back to the earliest systematic speculations on the nature of

THE EDUCATOR, THE PRACTITIONER, AND THE CONSUMER: PARTNERS IN THE HEALTH DELIVERY SYSTEM.

HEALTH STATUS & PRACTICES OF SOCIETY



AUTONOMOUS RESPONSIBILITY:

PUBLIC:	STANDARDS OF HEALTH
EDUCATION:	STANDARDS OF TEACHING AND RESEARCH
SERVICE:	STANDARDS OF CARE

SHARED RESPONSIBILITY:

STANDARDS OF PRACTICE IN THE OPERATION OF THE HEALTH CARE SYSTEM TO ACCOMPLISH THE STANDARDS OF HEALTH, EDUCATION, AND SERVICE

human society. Indeed, Plato's Republic remains to this day the most penetrating analysis of the interdependence of education and society to recount Plato's argument:

> In order to talk about the good life, we have to talk about the good society; and in order to talk about the good society, we have to talk about the kind of education that will bring that society into existence and sustain it. Hence, there is no vision of the good life that does not imply a set of educational policies; and conversely, every educational policy has implicit in it a vision of the good life.

Thus, university education has essentially a dual purpose; the first to provide a general education aimed toward developing individuals' potential as fully as possible, to think creatively; and to invest themselves in shaping society based upon internalized principles of ethical and moral integrity. The second purpose is to provide a career-oriented education designed to prepare the individual for a specific profession or occupation, with the essential competencies and principles to begin practice in a particular field. It is in career-oriented education that the individual acquires a particular role and identity in society, as well as the potential competencies for earning economic security.

These two educational purposes must remain interrelated and balanced. Both contribute to the good life, to society as a whole, and to the individual and family. An individual cannot hope to contribute significantly to innovations in his occupation or profession or to adapt to shifting demands for new knowledge and competencies without a general education. Likewise, an educated person cannot hope to contribute significantly to society and the good life without a particular role and identity in that society, which comes largely from one's professional work.

In addition to educating students, the University is responsible for research, or discovery of new knowledge. An institution of higher learning is that scholarly community to which society has delegated the rights, privileges, and responsibilities for exploring new knowledge and disseminating discoveries to society for appropriate and innovative application.

In order to fulfill its mission, the University has been given the right of academic freedom, thereby insulating the scholarly community from the cultural and time-bound values which can repress exploration of creative and sometimes unpopular ideas. This special privilege allows for experimentation in the "safe" environment of the scholarly community so that ideas and strategies can be sifted through a systematic and thorough series of tests before being applied in society-at-large.

The University needs the outside community, in our case nursing service, to participate in the identification of researchable problems

and the changing needs of society. In service community needs the scholarly community as a way to experiment and discover methods by which to advance the profession and positively influence the evolution of a healthy society.

The Need for Collaboration between Nursing Education and Service

A counterproductive dichotomy between nursing service and nursing education which developed out of an historical perspective has existed far too long. There are at least two dynamics which tend to interfere with an effective partnership between nursing service and nursing education:

1) An affinity for consensus, and

2) Perceptual blocking.

First, nurses seem to have a proclivity, if not a desperate longing, and thus tend to cluster into like groups where some comfort in agreement can be achieved. Nurse educators cluster together and engage in soporific monologues with one another on values, theories, and terms that they find mutually comfortable. We call this the ivory tower syndrome. Likewise, nursing service personnel gather together and exchange common views about all the things nurses should be able to perform to get the tasks done within institutional hours, policies, and procedural rules; to keep the costs down; and to make the doctors happy. This we call the brick wall syndrome. Worse yet, each faction continues to expound among its own members about how the other group is the cause of all the problems. This we refer to as the town-gown adversarial stance.

Service complains that graduates lack skills in acute care; that they cannot accept realities; and that they cannot set priorities. Educators express frustration that there is little opportunity to bring about needed change in nursing through graduates if they are not taught principles and competencies appropriate to future trends as well as to current practices. Are new graduates equipped to handle the transition from school to practice? Are institutions, other health practitioners, and nursing service itself, willing to let them try? New graduates' frustrations lead to more chronic conditions of reality shock, dissatisfaction, attrition, and nurse shortages.

Neither group is right. The point is that neither group wins; not nursing service, not nursing education, not the institution, not the new graduate, and, worse yet, not the client. To meet the needs of clients; to function in the evolving health care system; to expand the scope of nursing's responsibility; and to achieve professional satisfaction for career stability--nursing must seek answers as a unified whole. This necessitates uniting nurses, confronting and productively utilizing diversity and conflict, to arrive at truly integrated resolutions. This will necessitate taking deliverate risks to move beyond the present comfort of consensus.

Perceptual barriers conceived of by service and education toward one another prevent the transcending of these self-imposed blocks toward real collaboration, and interfere with an accurate perception of alternatives.

- Can we risk dealing with the perception that nursing service is less theoretical and only interested in the traditional and the practical?

- Can we risk dealing with the perception that nursing education is disinterested in the skills needed to accomplish tasks and in the actual acquisition of clinical competencies?

Until we do risk these encounters, we will not discover the obvious--that nursing service and nursing education share a common key to effective nursing practice, and thus to the means by which to fully mobilize nurses as a major national resource for comprehensive health care.

The first step is to break the powerful perceptual barriers which preclude the ability for each to see the other's point of view, to increase tolerance for creative conflict, and to risk bargaining together for a mutual resolution which will benefit the client and the health care system.

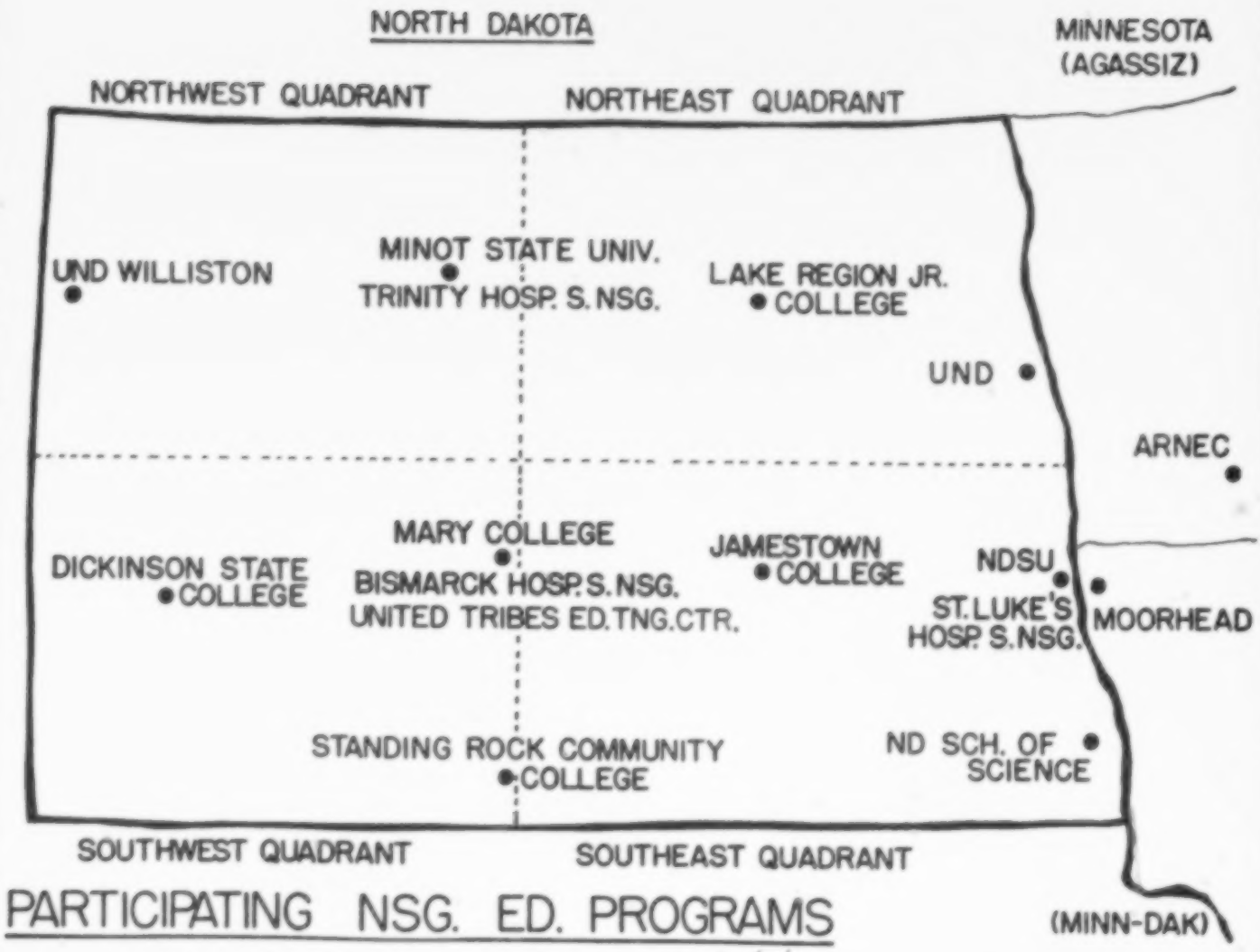
We need to risk confrontation and creative solutions on critical issues such as the appropriate preparation for nurses, the locus of responsibility for nursing education, the scope of nursing practice, the collaborative relationship with medicine, the accountability to the client versus accountability to institutional policy.

We need an evolutionary model to identify the respective roles of service and education in preparing nurses for practice, in promoting discovery, and in advancing our profession. We know that this cannot be achieved in isolation and that cooperation is essential. To this end North Dakota has established a consortium to serve as a facilitating mechanism for collaboration.

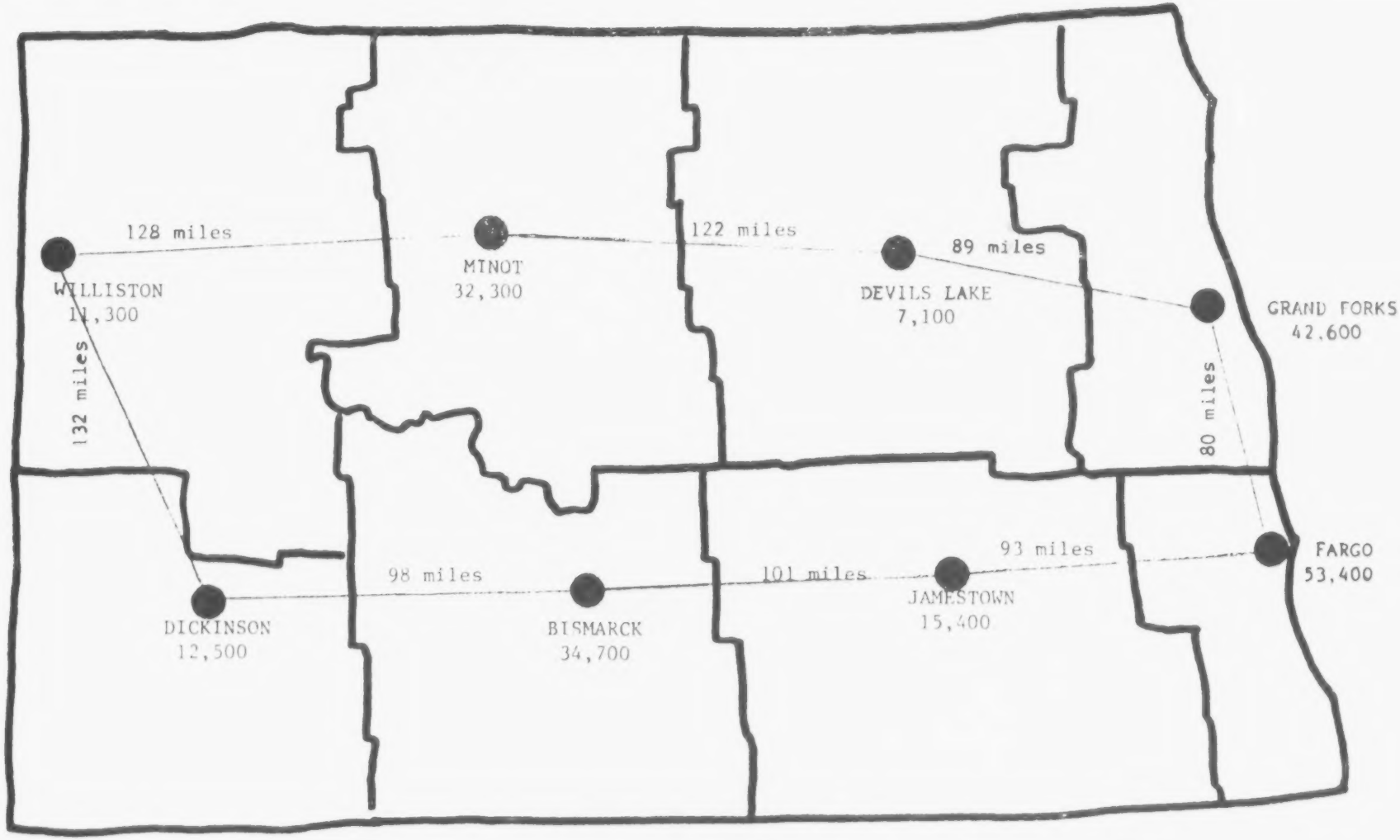
The North Dakota Nursing Education Consortium (Figure 2) (Figure 3)

This new organization, founded in 1977, is dedicated to the advancement of nursing education throughout the state of North Dakota as well as overcoming significant maldistribution and isolation problems of nursing resources. Education consortium has been supported by funds from the Area Health Education Center program.

The Consortium's purpose is to tie together the statewide planning of three key components of the nursing profession: (1) nursing service, (2) nursing education, and (3) nursing organizations. Membership consists of the following from each group:



PARTICIPATING NSG. ED. PROGRAMS



DISTANCES AND POPULATIONS OF MAJOR CITIES OF NORTH DAKOTA

(1) Nursing Education: Administrators and selected faculty of all of North Dakota's nursing education programs, including four baccalaureate, two associate degree, three diploma, six LPNs, and one family nurse practitioner program.

(2) Nursing Service: Administrators and staff nurses from all geographic corners of the state representing various areas of nursing practice; and the Director of Nursing for the State Department of Health.

(3) Nursing Organization: The president and members of the State Nurses' Association, the Citizen's League, the Student Nurses' Association, the North Dakota Board of Nursing, the Licensed Practical Nursing Association; as well as a representative of vocational nurse aide training.

In addition to nursing groups, the Consortium includes participation from the planning community--the three Health Systems Agencies and the Statewide Health Coordinating Council.

The North Dakota Nursing Education Consortium focuses its attention on state-level planning and coordination in nursing education. This focus is depicted in two conceptual models, Figure 4 and Figure 5; one describing its concentration on coordination in nursing education in the context of health planning in general. Figure 6 outlines the linkages among nursing service, nursing education, and nursing organizations in reaching the mission of the Consortium.

Early on, the Consortium identified the educational needs most prominent in North Dakota; and these needs suggested the four goals for coordinated efforts in nursing education:

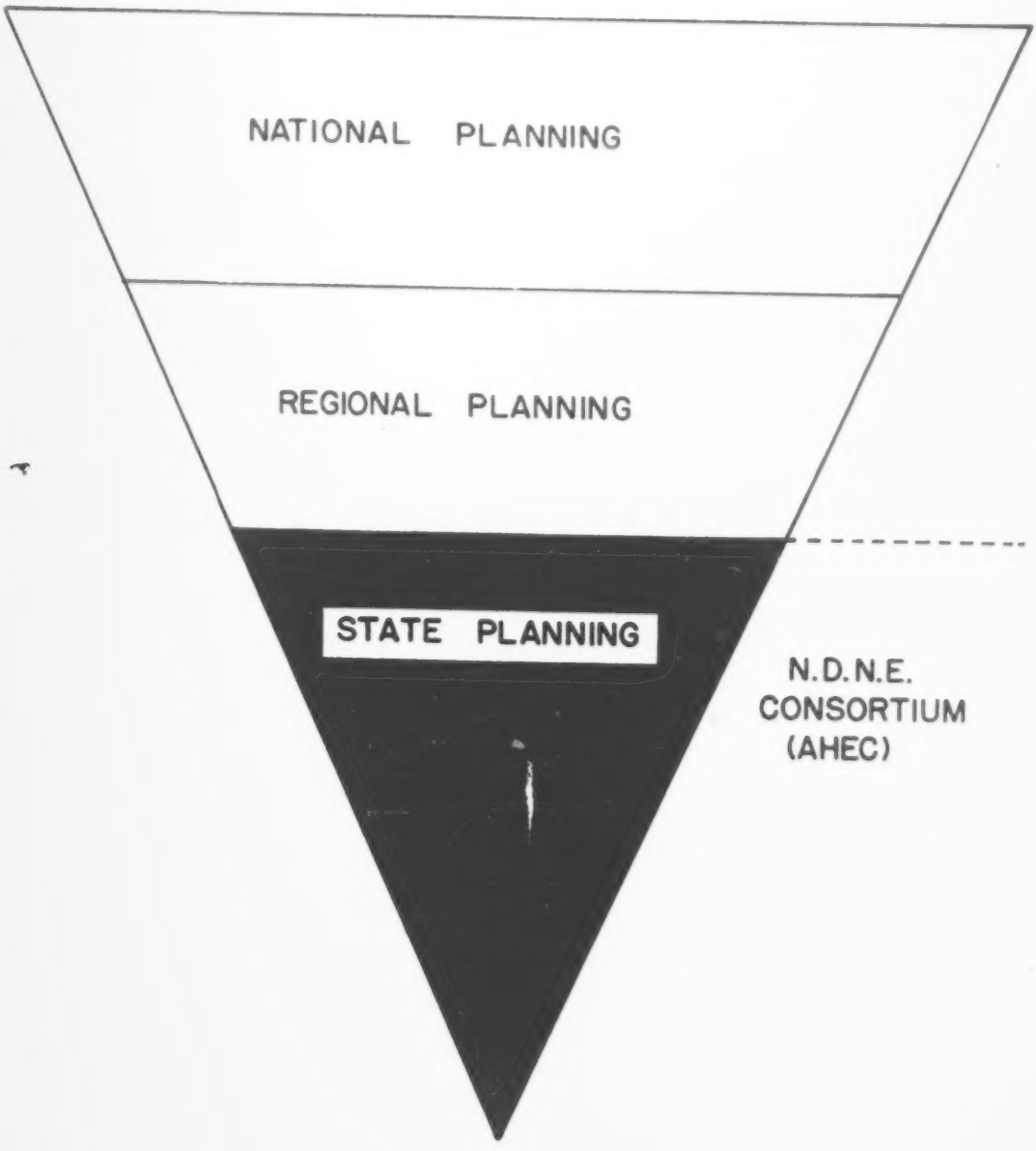
(1) To improve the accessibility of graduate education for nurses in North Dakota.

(2) To develop a statewide network in continuing nursing education for practicing nurses.

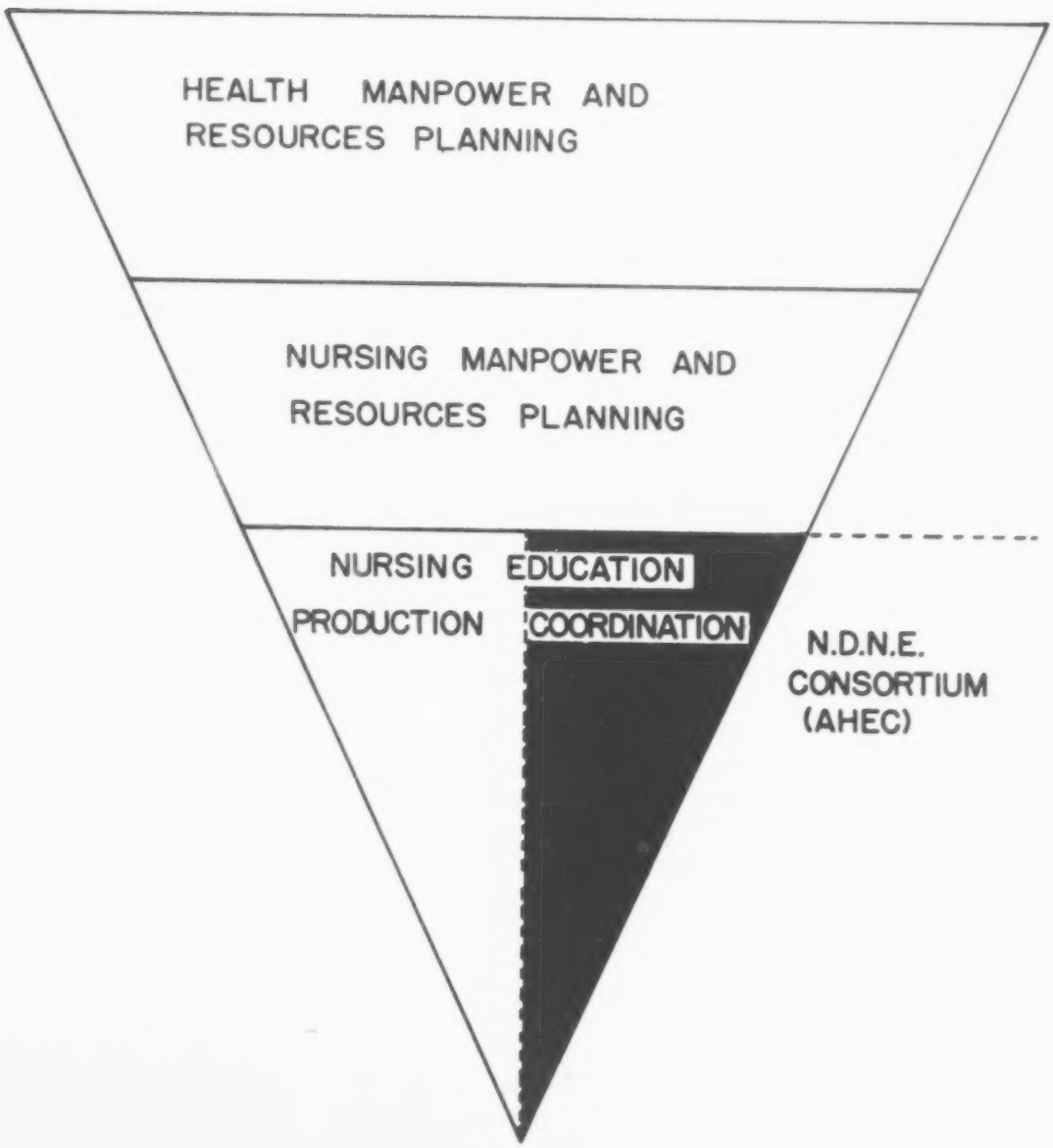
(3) To create a plan for more effective educational and career mobility for nurses.

(4) To expand the utilization of extramural education for nursing students in primary care, expanded roles, interdisciplinary collaboration, and nursing in rural settings.

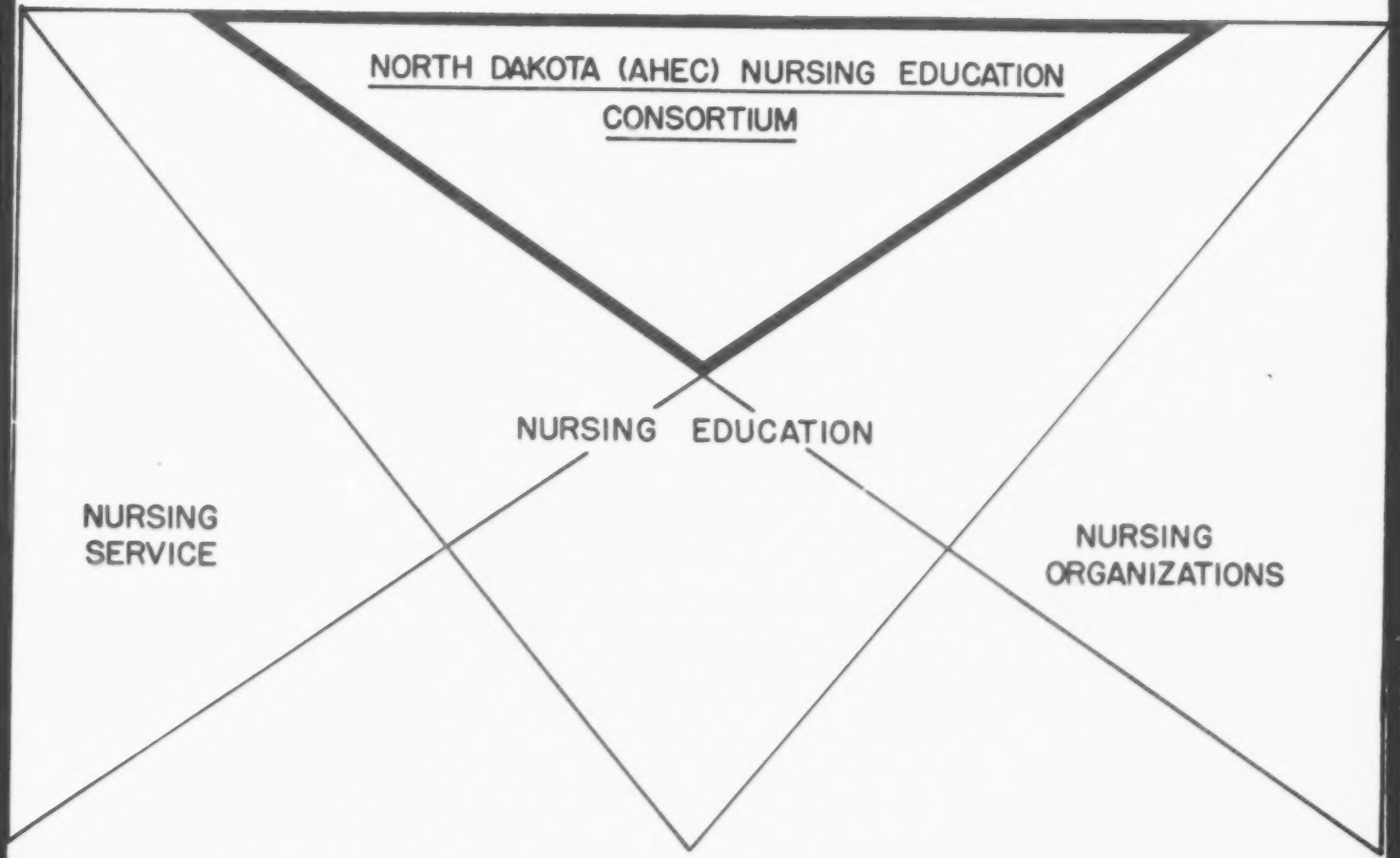
GEOGRAPHICAL SCOPE



FUNCTIONAL SCOPE



COOPERATIVE RELATIONSHIPS
LINKAGES



The Consortium's organizational structure developed around the principal mission of collaborative planning and these four goals.

The Consortium is organized into a Council and three standing committees. The Council is composed of the executive officer of each institution, organization, and representative group; for example, deans or chairpersons of educational institutions, directors of nursing services, and presidents of organizations. The Council provides overall direction in the Consortium, serves as a catalyst in the initiation of planning for nurse supply and distribution in North Dakota, and plans activities related to graduate nursing education.

The goals pertaining to continuing education, career mobility, and extramural education are delegated to three committees:

(1) The Continuing Nursing Education Committee

(2) The Career Mobility Committee

(3) The Extramural Nursing Education Committee.

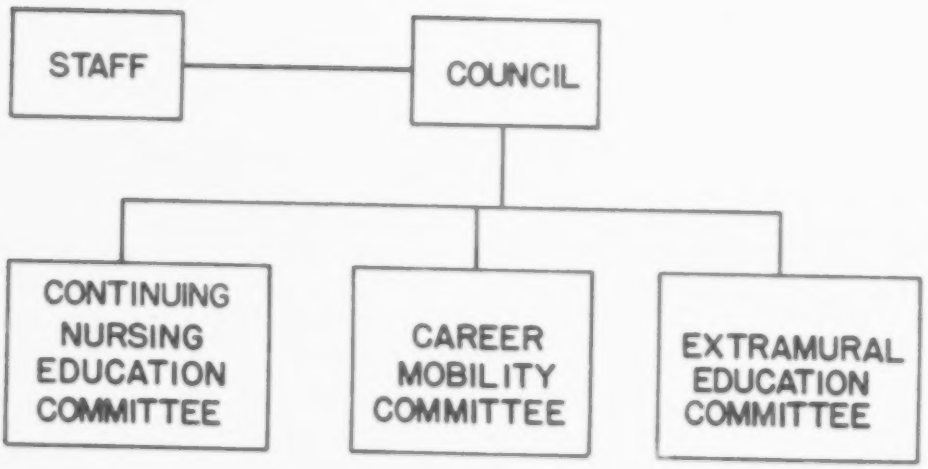
These committees are each composed of a representative nurse from each of the institutions and organizations participating in the Consortium. Thus, each educational institution is represented on the Council by the Dean and on each committee by a different faculty member. Likewise, nursing service and the various organizations are represented on all four groups (Figure 7).

The Consortium developed guiding documents including its philosophy, assumptions, and by-laws. Throughout the year, each group meets both in person and by way of the Educational Telephone Network which reaches over 20 communities and 34 sites in the state (Figure 8).

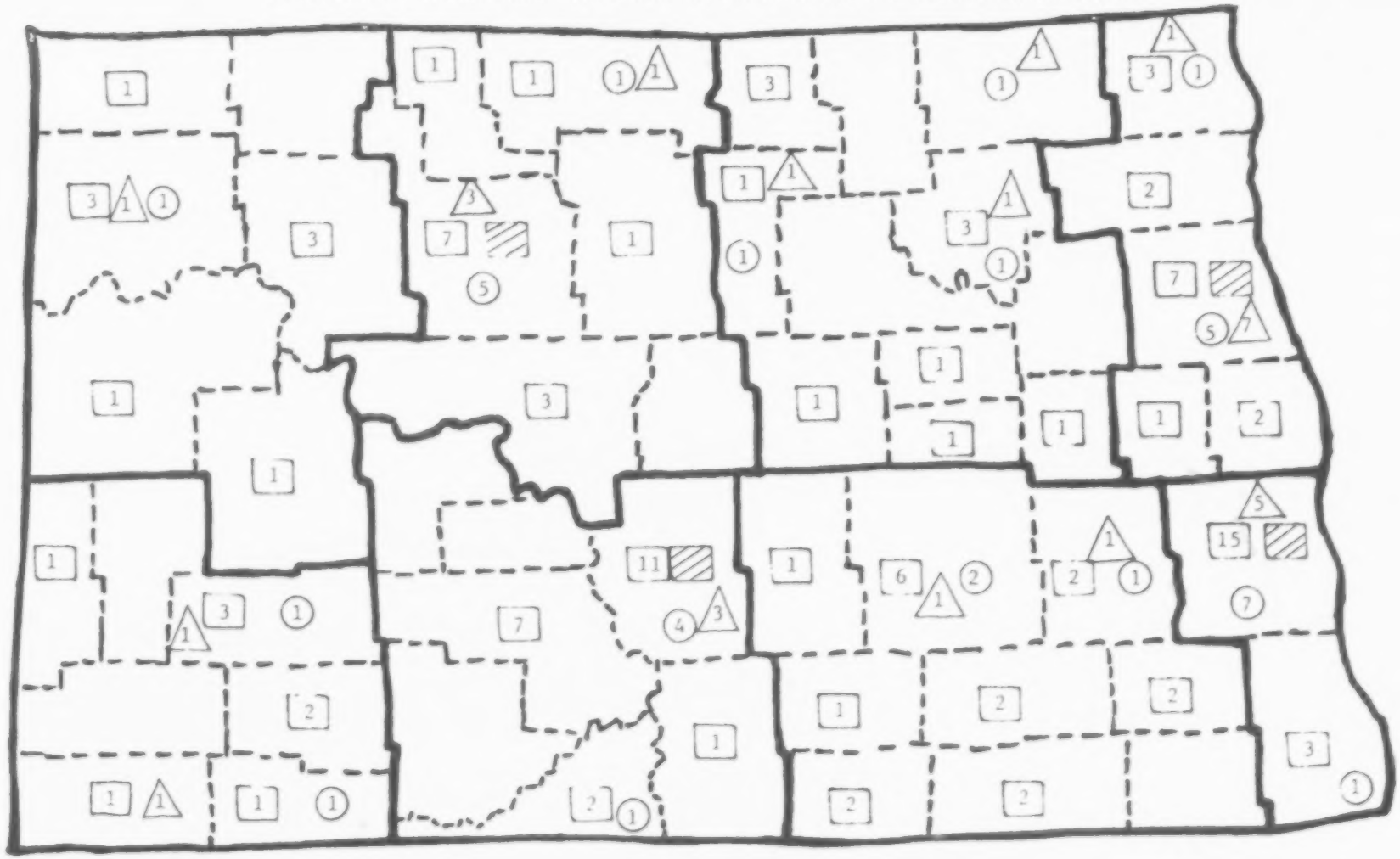
Major accomplishments of the Consortium.

(1) Council: The Council has organized two major accomplishments in the area of graduate education. First, North Dakota has entered into a productive relationship with the University of Minnesota whereby courses in this Master's degree program were brought into North Dakota for closer accessibility to the state's nurses. Four core courses or 12 credits of graduate work were taught in North Dakota during the summers of 1978 and 1979. Subsequently, a contract was developed between the University of Minnesota and North Dakota, whereby North Dakota funds were allocated to provide a contract fee for "slots" in that program as well as a stipend allowance to nursing students while on the Minneapolis campus. Over the years 1979-1981, 28 North Dakota nurses will have obtained their Master's degree in Nursing through this project. A second thrust was the Council's efforts to gain statewide support in legislative funding for the development of a Master's program in nursing at the University of North Dakota.

NORTH DAKOTA NURSING EDUCATION CONSORTIUM ORGANIZATION



LOCATIONS OF EDUCATIONAL TELEPHONE NETWORK SITES AND LIBRARIES BY COUNTY



○ Educational Telephone Network Sites - 34

△ UND/A-V Carrel Sites

▨ Midwest Health Science Library Network Libraries - 4

□ Total Number of Libraries (all types) by County - 102

In addition to the Council's activities in graduate education, this group has initiated a project to develop a comprehensive plan for nursing supply and distribution. The Council has acquired consultation from Jeanne Kearns of the Western Commission for Higher Education in Nursing (WCHEN). The actual planning project will include three communities of representatives: Nursing, planning, and post-secondary education.

(2) Continuing Nursing Education Committee (CNE): The C.N.E. Committee has created a plan for a network in continuing education for nurses in North Dakota, made up of regional coordinators and advisory committees for local activity; and a central coordinator and steering committee for the planning and distribution of shared resources statewide. This plan has been written into a grant recently submitted to the department of Health and Human Services.

(3) Career Mobility Committee: This Committee has produced a brochure on nursing educational opportunities across North Dakota. It clearly outlines the various types of programs, their mission and differences, and future trends in professional nursing education. This brochure has been used broadly by prospective students and by counselors across the state.

The Committee is now assessing the articulation mechanisms utilized by each program in the education of registered nurse students, with the anticipation of collaborative efforts to improve accessibility of baccalaureate education to registered nurses.

(4) Extramural Education Committee: The Extramural Committee is completing a manual for use by all nursing programs, which outlines guidelines for preparing extramural offerings and resources in extramural education across the state. The plan is to place nursing students in model sites for experiences in primary care, interdisciplinary activities, and rural health delivery. This is already in operation in many areas, notably the senior-level options course required of all students in the University of North Dakota nursing curriculum. Students contract for their own learning, with faculty advicement, and engage in a comprehensive and intensive experience in a selected area of nursing practice. Included are experiences in community assessment, cost analyses, and other reality-orienting opportunities. The experience offers students a change to 1) experience some of the reality shock characteristic of practice, 2) gain proficiency in a particular area of practice, and 3) explore career opportunities in a particular geographic location.

(5) Consortium in General: Each year the Consortium holds a major meeting of all 116 members (Table 1). In 1978, the focus was on the planning process. In 1979, the focus was on the planning process. In 1979, the concentration was on the partnership between nursing service and nursing education. This summer the Consortium examined credentialing and its impact on nursing practice. National leaders are invited to the state to present their views in these major conferences.

1979

NUMERICAL TABULATION OF NORTH DAKOTA
NURSING EDUCATION CONSORTIUM MEMBERSHIP

	Council	Continuing Nursing Education	Career Mobility	Extra-mural Education
Educational Programs	19	17	17	19
Nursing Organizations and Agencies	6	6	4	6
Nursing Service	4	4	2	4
Health Planning	4	0	0	4
	33	27	23	33

Total = 116

The North Dakota Nursing Education Consortium serves as a useful mechanism for collaboration in nursing, with a particular focus on the learning needs of North Dakota nurses. The belief of the Consortium is that the quality and accessibility of health care in the state is largely dependent upon the provision of nursing care by individuals who are competent nurses, learned persons, committed professionals, and effective leaders. To accomplish this mission requires the total investment and unity of nurses. That takes collaboration.

The Need for Collaboration

Perspectives of Nursing Service
A Personal Account

Beth Roder, Director of Nursing Services, Cavalier County Memorial Hospital, Langdon, North Dakota

Preface

About three years ago I met the newly appointed dean at the University of North Dakota College of Nursing. I had already met and worked with the faculty of several other schools of nursing in North Dakota. I looked forward to establishing a working relationship with the new dean.

My first meeting with Dean Zinser was far more than what I had expected! She gave me her undivided attention as I addressed the shortcomings of new graduates as well as the concern I had for the limited career mobility opportunities in our area. She gave me a little background on the challenges which schools of nursing face. At the close of our conversation she suggested that I serve on the North Dakota Nursing Education (NDNE) Consortium subcommittee for Career Mobility. This is how I became involved with the NDNE Consortium.

Exigencies in Rural Health Care

In rural America we are faced with staffing acute care and long-term care facilities with the registered nurse who must necessarily become a jack of all trades. The nurse may be the only RN to handle emergencies, deliveries, surgical treatments, admissions, and a variety of other activities that may arise. This, and geographical remoteness from metropolitan centers, make it difficult for some institutions to recruit and retain new graduates. Also, the cost containment measures used by some hospital boards, administrators, and nursing administrators may preclude adequate nurse coverage. These cost containment measures are often accompanied by lack of commitment to adequate wages, benefits, and staff development, and recruitment programs. Often nurses are not allowed to perform at their fullest potential.

Systems analysts claim that an RN can be utilized 100 percent of the tour of duty; the LPN, 65 percent, and a nursing assistant 38 percent of the time. It would stand to reason then that the RN is the best utilization of resources.

It comes as no surprise that there are areas in rural America in which a new graduate is briefly oriented and then becomes the only RN on duty. This practice, although inappropriate, happens frequently. Alternatives seem limited for the nursing administrator when there are so few nurses available to work.

Expectations in such a setting may be too great for a new graduate. For some, being placed in a supervisory role represents an exciting challenge; but for most it is reality shock from which they never recover. Consequently, these people leave nursing or the community or both before they have had adequate time to practice their profession.

Some institutions provide a well structured orientation program. The length of the orientation may vary from one to six months with close supervision and frequent dialogue with supervisors and other new graduates; and may include a buddy system with floor personnel.

Positions available to new graduates vary with locality and size of facility or health service departments with which the graduates accept employment. Most of the rural facilities find it necessary to hire an RN without regard to educational preparation. Preference for hiring graduates is typically given to nurse applicants who have acquired some experience with traditional nursing skills. Some of the more progressive health care employers will hire for potential and not just for skill proficiency, realizing that although skills are important; the capacity for problem solving, leadership, and commitment are also vital ingredients. Some programs cannot provide adequate opportunity for the student to practice due to an overload of affiliating students and the infrequency of particular types of procedures in the clinical setting. Making these opportunities available is an important aspect of the clinical administrator's responsibility.

Unfortunately, charge nurse positions may be assigned to a new graduate as soon as notification that the state board examination has been passed.

Salaries for new graduates range from a very basic rate set in the institution for graduates to the same rate than any RN's employed in the institution are receiving, without respect to education, experience, capability, or potential.

Data collected from nursing administrators in the Midwest who are in charge of hospitals and nursing homes varied in size from 15 to 500 beds or more; and public health departments which had as few as four staff showed that nursing students need more clinical experience. Additional clinical experience would give the new graduates an extra measure of self-confidence as they enter the work force.

Performance differences among graduates in our setting have been attributable not only to the institutions from which educational experiences were gained, but also to the individual's interest and motivation for being a nurse. Maintaining and promoting the nurse's motivation in the face of today's practice stresses represents a challenge for both educators and nursing administrators.

Through collaborative dialogue and sharing of resources, nursing service and education can move ahead, learning to compromise, and to expand their perception of initial objectives so as to develop workable alternatives. Clinicians and educators both realize that no one can be the winners until the patient/client can be shown to benefit.

Financial constraints limit the options of both service and education. Hospital administrators are hard pressed to put more dollars into orientation and in-service when turn-over is great. However, some institutions have realized a net savings by designing a structured hospital-subsidized orientation and in-service program which provided staff greater satisfaction with their work and helped to reduce staff turnover.

It is advantageous for the student to be exposed to more than one health care setting to experience for themselves some of the many opportunities in nursing practice. Particularly, more nursing experience in rural settings is necessary. As we consider the rural midwest, which MAIN encompasses, are there too few small facilities involved with this organization? How do educators learn of student opportunities beyond their own metropolitan settings? Through what channels can nursing service reach out to the schools of nursing to initiate collaboration? What special learning opportunities can we in rural settings offer to educational programs?

Our roles in nursing service can be adapted to accommodate the outcomes of new and innovative educational programs. Together we can learn to accept problems as gifts through which we may build a stronger and a more committed nursing force in the Midwest.

Educators are beginning to work in settings in which students obtain part of their clinical experience. It is difficult for the students to find role models in teachers who have infrequent opportunities to work with "here and now" nursing. Conversely, nursing service people have a responsibility to keep themselves current with the trends in the field. Service establishes the climate for the clinical experience of teachers and students. Both educators and nursing service personnel, as role models will need to collaborate to find concurrence on basic assumptions in caring for clients.

Along with teachers and nurses on the wards, let us also consider the graduates. Spoon feeding experiences to the students from 8 to 5, Monday through Friday will not provide the model for professional development. Learners must seek out and accept responsibility for a broad range of opportunities as they realistically arise in practice. Much to the surprise of some graduates, professional nursing includes weekends, nights, and holidays.

Orientation or in-service programs in which new graduates contract for their own learning can be jointly developed concentrating on the competencies of the beginning practitioner in that agency. Cooperating health care facilities and agencies could also commit time and necessary resources to enable these individuals to use the knowledge background they have. Nursing service should not be so skills-oriented that the futuristic trends that enhance patient care are neglected.

In working with the career mobility committee in North Dakota since its inception, I was at first the only service person in attendance. Quite frankly, I felt like Daniel in the lion's den among those educators. But since then I have become cognizant of the constraints, time and financial, that educators deal with in preparing our nurses. First there must be a commitment on behalf of the nursing administrator or representative of the health care setting.

Participation in the work of the committee has depended on frequent use of the educational telephone network in North Dakota. This vehicle has been used for several of our committee meetings this past year. Otherwise the distance I would have to travel would have been prohibitive. Also because of the Consortium's secretarial staff support we were able to keep up with the projects which the committee has attempted and completed.

Changes on the horizon in our state have been initiated by this collaborative Consortium. In the September issue of Quest '80, futurist Peter Schwartz offers his opinion and insight through an interview with editor/writer Joseph Spieler. Mr. Schwartz believes that there is an increasing appreciation for adaptive intervention rather than problem solution; and that the trend toward incremental adaptations leads to gradual amelioration of complex issues rather than abrupt confrontation by juxtaposed resolutions.

One senses that this trend may also apply to nursing. Changing roles, entry into practice issues, numerous splinter groups seeking credentialing, licensing, and recognition may threaten us with the loss of the old way of doing things and paralyze our forward thrust. But, if we work together sharing facilities, personnel, and ideas, we can bring about our own adaptive interventions. As the strings on a violin need tension for making music, there is necessary stress on both instrument and strings. To make beautiful music, the musician needs knowledge of the instrument and he needs to know the song. With practice, tension applied to the right place on the strings, he combines skills, knowledge, and feeling for the perfect performance.

Educators and clinicians alike can be seen as musician and instrument with tension and stress used creatively for the best interests of the patients. The beautiful music of expert nursing care can be born out of collaboration between compassionate nurse professionals despite differences in their institutional settings.

Need for Collaboration -

Transition from School to Practice

J. Jean Mellum, R.N.

On Becoming a Nurse Person

I became a person before becoming a nurse, and because of my person I am the nurse I am. Yet, the person and nurse I am today is not the same as it was yesterday or as it was last year.

I was a practicing L.P.N. before beginning my R.N. education. And now, twenty years later, I am here before this gathering of professional nurses to begin my presentation with the basics. . . cell division.

Reproductive cells, as you know, give rise to the egg and sperm cells by a form of division known as meiosis. It is the random distribution of maternal and paternal chromosomes during meiosis that provides the basis for much of the variability in the genetic constitution of any person.

After conception, mitotic cell division and differentiation results in a multicellular organism and is an extremely complex process. This process of cell division, mitosis, may be likened to the conception of a nurse. Beginning with the student's choice of a school as an academic parent, educational mitosis begins. Acquisition of knowledge begins with the first class, cell division is rapid, and the knowledge base expands. Within each student, genetically and academically, the formation of a nurse is different, yet the same, because of the common goal . . . to prepare for entry into the health profession.

I am fortunate to have been able to be at opposite ends of the nursing spectrum. The practice role setting as a student L.P.N. prepared me well for the nursing role I was to work in. I felt competent to practice as an L.P.N. It was a limited, safe role, always under the direction of an R.N. I now know the considerable difference between performing as an L.P.N. and becoming a professional nurse. I shall allude to that later.

The Importance of Valuing Variability

As an L.P.N. and as an R.N. I am skilled at delivering direct care with TLC. In addition to TLC when I care for patients I include my own personal approach, G.T.N. (Gentle Touch Nursing). When I communicate with patients I touch them. I have always believed that it was and is my gentle touch that conveys the caring message. Several times during my student L.P.N. and R.N. educational process I received negative comments from instructors concerning my communication approach. G.T.N. is one of my variabilities. The growth of a student can be hampered if instructors do not consider the valuable variabilities in the person who is becoming a nurse.

I have not experienced being a graduate of an A.D. or Diploma program but have worked with many nurses from these types of programs, listened to descriptions of their learning process and discussed the differences that exist. The most frequently expressed complaint by L.P.N.s, A.D., and Diploma graduates about B.S.N. graduates is that they lack performance skills. Unfortunately the L.P.N.'s, A.D. and Diploma graduates have not experienced that extra growth into the professional nursing role.

Professional nurses understand and implement the nursing process and ideally utilize this thinking process in their personal as well as professional lives. I understand the nursing process to be a thinking process that includes the total environmental health needs of consumers and the distributors of health care. Ultimately the professional nurse has stable self-esteem, is non-judgmental, is a self-evaluator, prepared and eager for growth within the self and the profession.

I am particularly appreciative of the preparation I received for the professional nursing role. I will not claim at this time to be able to perform all the technical skills necessary for hospital nursing. I am currently employed as a Community Health Nurse in a rural Minnesota area. The skills I use when working with clients are varied and would fill volumes if I had the time to document them. My working days include assessing, evaluating, referring, and counseling. My clients are newborn infants, single parents, depressed mothers, battered women, sexually abused children, physically and mentally abused children, children with epilepsy, cancer, cystic fibrosis, and cerebral palsy. I organize and implement Early Periodic Screening clinics and do physical assessments at Preschool Screening clinics. I counsel parents providing them with guidelines to improve their parenting skills and will be teaching pre- and post-natal classes. The cultural backgrounds of the families I visit include Spanish, Vietnamese, Laotian, Native Americans, Irish and German Americans, and even some unique families who recently migrated from the hills of Missouri. I have learned to accept traditional Native American medicine, attended a Pow Wow, enjoyed South Asian hospitality. Many of the homes I visit have only the bare essentials to sustain life, have no running water, heat their homes with wood, are lice infested, and some share their homes with their animals, even goats. This professional nurse person accepts these people as the special people they are.

My person has grown, the professional nurse in me is well established. Graduates of programs other than B.S.N. programs are frequently employed in Community Health nursing. However, I feel that as a B.S.N. graduate my transition from school to practice, particularly this type of practice, was greatly enhanced by the education I received in the baccalaureate program.

Needed Clarification of Nursing's Educational Programs

The differences in expectations and perceptions of the nurse's identity by faculty, nursing employers, consumers, the general public, physicians, and the practicing nurse are in need of clarification to many.

During a nurse's education the faculty and instructor's expectations should be high. The higher the expectations the more prepared the new graduate will be for reality.

Nursing employers especially should educate the nursing staff within their own health care facility as to the different educational preparations each type of nursing program presents. If staff nurses understood these academic differences it might ward off the frustrations experienced by graduates from different programs and the expectations they have of each other. Such a program of familiarization could be implemented through in-service classes presented by staff members themselves.

If patients, the innocent recipients of our care, better understood the educational preparation of the nurses rendering their care, they could better utilize the direct and indirect services available to them. Informing consumers of the differentiation in nursing educational programs, and the services that each type of nurse is prepared to provide should continue to be an ongoing objective of the profession.

There is also need for consensus-building regarding expectations and roles of new graduates. We are still captives of the old school's rapid growth, and the accelerated progression of the profession. The needed consensus must begin within the profession and then expand to employers, consumers, physicians, and the general public. Furthermore, the need for orientation and in-service for new graduates should be required to be specific to the health delivery role they are expected to fulfill. Continuing education should entice nurses to keep in touch with all generic aspects of the profession, including quality assurance workshops, management strategy, trends in nursing, and research and evaluation seminars.

Career planning and counseling could be an expanded responsibility of the student, the recent graduate, nursing schools and employers. Support systems could evolve to provide each new graduate with a faculty counselor contact available to him/her for the year after graduation. Such a program could have considerable impact.

In fact, I would appreciate having this type of contact right now as I am trying to decide on the direction of my professional nursing future. Should I remain a Community Health Agency staff nurse? Should I enroll in a Master of Business Administration program or a Master of Nursing Program? Should I job hop to another more challenging position? These questions deserve answers, and having a direct professional contact with whom to discuss these questions would be very beneficial.

Staff nurse support systems could be established within health care facilities. A buddy system as an adjunct to the required orientation would entail assigning a co-worker to be a supporter of the new graduate for the first three to six months of employment. Experienced L.P.N.s could be paired with new B.S.N. graduates, and new A.D. graduates with experienced Diploma nurses in a deliberate mix and match design. If this were part of both the experienced employees' job description and the new

graduates probationary time, with guidelines offered, and evaluations of experienced and new employees to include an assessment of the quality of their collaboration; might this begin to eliminate the misunderstandings that occur between the more experienced nurse and the new graduate?

Perhaps some of these ideas have been thought of before and are being implemented now. They are suggestions derived from my own views. As a neophyte in professional nursing, I come with my personal perspectives. And, because of my person, I am the nurse I am.

SECTION V

ADDITIONAL EXAMPLES OF SERVICE - EDUCATION COLLABORATION

Although not a part of the MAIN sponsored program of September 16, 1980, additional examples of service/education collaboration were submitted to MAIN in response to queries for collaborative examples included in MAIN's July 1980 Newsletter (Vol. 1, No. 2, p. 17). These short and less structured examples are included in this monograph to provide as composite a picture as possible of programmatic trends throughout MAIN's region.

Iowa

S. Kay Montgomery, Chairperson
Colloquium of Nursing Leaders of
Central Iowa
Director, Nursing Service
Iowa Methodist Medical Center
1200 Pleasant Street
Des Moines, IA 50308

THE COLLOQUIUM OF NURSING LEADERS OF CENTRAL IOWA

The Colloquium of Nursing Leaders of Central Iowa was organized in May 1978. Its current membership includes representatives (Directors of Nursing or equivalent title) from hospitals in Des Moines and Ames, schools of nursing in the area including one BSN program, one ADN program, two diploma programs, and one LPN program, the Public Health Nursing Association, the State Department of Health, the Iowa Nurses' Association, the Health Systems Agency, the Iowa Board of Nursing, and the Iowa Hospital Association. Two members also occupy important positions of influence regarding health care. One is chairperson of the Statewide Health Coordinating Council (SHCC) and one is president of the Iowa Health Systems Agency.

The purposes accepted by the Colloquium are to exchange information, share ideas, offer mutual support for common problems, and to communicate identified needs to appropriate resources.

The philosophy adopted by the Colloquium is:

Collaboration between nurses in leadership positions will help to achieve the highest quality of nursing care through the sharing of ideas and information.

Collaboration will facilitate planning in the area of nursing practice and education.

Collaboration within the Colloquium will act as a support to the members. New members will be assisted to be cognizant of the trends, issues, and goals of nursing.

Collaboration will promote communications with appropriate resources.

Although we meet only quarterly, our members have found these contacts valuable. For many there had been no contact before. Directors of hospital nursing services met together regularly and directors of schools of nursing met periodically but we never met together. Many of us knew who other people were but had not had the opportunity to discuss issues of mutual interest. The Colloquium provides that forum.

All members feel better informed as a result of this contact, and we look forward to continued associations which will benefit us all.

As in a fertile field, ideas germinate in the Colloquium where they grow and expand. Although the Colloquium itself is not the instrument bringing these ideas to fruition, it serves an important function in giving them birth.

Iowa

Darleen Sickert, R.N., M.P.H.
The Public Health Nursing Section
Iowa State Department of Health
Lucas State Office Bldg.
Des Moines, IA 50319

and the

Continuing Nursing Education Department
101 Nursing Building
Iowa City, IA 52242

The Public Health Nursing Section, Iowa State Department of Health, has met with the University of Iowa Continuing Nursing Education personnel for several years to collaborate on educational programs to meet some of the learning needs expressed by Public Health Nurses.

In addition, the Iowa State Department of Health/College of Nursing Faculty liaison Group on Community Health Nursing has been meeting since 1978 to discuss learning needs of county Public Health Nurses in Iowa. After several meetings the Assistant Dean of Continuing Education for the College of Nursing also joined our group. Results of group planning are:

1. A three-day workshop presented in one-day sessions over a period of six months on "Assessing the Community's Health Status: A Basis for Planning Nursing Services." The course was offered for continuing education credit.

2. A plan to develop a long distance learning course in Basic Public Health Nursing given for college credit.

3. A plan to do some research to evaluate baccalaureate educational preparation in Public Health Nursing practice.

Minnesota

Elaine Richard, R.N., M.S.
Co-Chairperson, Nursing Service/Nursing Education
Dialogue Committee
District III, Minnesota Nurses' Association
Griggs-Midway Bldg.
St. Paul, MN 55104

A COLLABORATIVE EFFORT BETWEEN NURSING SERVICE

AND NURSING EDUCATION IN MINNESOTA

The Minnesota Nurses' Association has an established Nursing Service/Nursing Education Dialogue Committee in the metropolitan districts III and IV. Its purpose is to provide a forum for nursing education and nursing service to exchange ideas and possible approaches to common concerns and come to a clearer understanding of each others practice areas.

This past year, this committee sponsored a dinner workshop on "The Nursing Shortage: Finding Solutions Together". Ninety-seven participants attended the program and listened as representatives of nursing administration, staff nursing, patient advocacy, pool nursing, MNA and nursing education presented their perspectives of the problem and how it affected them personally. Participants then engaged in small group problem solving activities and made recommendations for resolving both the short- and long-term effects of the shortage.

As a result of this successful program, the committee developed a tool "Interdisciplinary Workshops - The Nursing Shortage" to assist hospitals in conducting similar dialogue sessions with their own personnel.

Missouri

Ann McCormack, R.N., M.S.
Coordinator, Nursing Education, St. Louis University School of Nursing/
Veterans' Administration Medical Center
St. Louis University School of Nursing
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COLLABORATIVE RELATIONSHIP

between

ST. LOUIS VETERANS ADMINISTRATION MEDICAL CENTER

and

ST. LOUIS UNIVERSITY - SCHOOL OF NURSING

During 1974 the position of Coordinator for Nursing Education was jointly approved by the St. Louis Veterans Administration Medical Center and the St. Louis University - School of Nursing. See attached Position Description.

The Coordinator is a member of the following School of Nursing Committees:

Committee on Continuing Education
Committee on Educational Resources
Committee on Undergraduate Curriculum
Committee on Planning
Psychiatric-Mental Health Nursing Section
Undergraduate Faculty

The Coordinator is a member of the following Veterans Administration Medical Center Committees:

Nursing Service Executive Committee
Clinical Pastoral Education Committee
Nurse Recruitment Committee
Continuing Education Committee
Nurse Studies Committee
Career Development Committee

To date, 18 Veterans Administration Nurses hold clinical appointments on the University School of Nursing faculty. The appointees are expected to attend faculty meetings, section meetings, and to participate in other committee activities as requested.

Sixteen University faculty members accompany the students to the Veterans Administration Medical Center. Fourteen clinical areas are approved for student education. Six faculty members hold Nurse Consultant appointments to Veterans Administration Medical Center Nursing Service.

University faculty are active members on the Veterans Administration Medical Center's Nursing Studies Committee, Continuing Education Committee and Procedure Committee. University faculty serve as resource persons for the Career Development Program, and for the Nursing Service Executive Committee.

University faculty are encouraged to utilize the Veterans Administration Medical Center for "release time" practice, for nursing research, and for summer employment. A method of calculating "contributed time" by the Veterans Administration Medical Center staff has been devised.

Approximately 300 University Undergraduate and Graduate students affiliate yearly with the St. Louis Veterans Administration Medical Center.

University students are advised of Inservices and Continuing Education programs, and they are encouraged to participate. Projects completed by the University students are shared with the Veterans Administration Medical Center Nursing Staff. Orientation and evaluation conferences are conducted by University faculty and Veterans Administration Medical Center Nursing staff for all students prior to and following each clinical rotation. Summer externships are offered for the University students by the Veterans Administration Medical Center.

Registered Nurses employed by the Veterans Administration Medical Center are entitled to Tuition Remission by the University to pursue a Baccalaureate degree in Nursing in the School of Nursing.

A free exchange of educational software and hardware has been implemented. The Veterans Administration Medical Center Microwave television system utilized between the two divisions of the Veterans Administration Medical Center and the University School of Nursing adds a creative dimension to the educational process.

TITLE OF POSITION: COORDINATOR FOR NURSING EDUCATION, ST. LOUIS UNIVERSITY/ VETERANS ADMINISTRATION MEDICAL CENTER

Description of Position

The position of Coordinator for Nursing Education, St. Louis University/ Veterans Administration Medical Center, is a joint appointment between St. Louis University School of Nursing and the St. Louis Veterans Administration Medical Center. The incumbent is appointed by mutual agreement of the Associate Chief of Staff for Education (St. Louis Veterans Administration Medical Center) and the Vice President of the St. Louis University Medical Center. Nomination of the incumbent is made by the Chief, Nursing Service (St. Louis Veterans Administration Medical Center), the Associate Chief, Nursing Service for Education (St. Louis Veterans Administration Medical Center), and the Dean of the St. Louis University School of Nursing, with the approval of the University Faculty Council. The Coordinator for Nursing Education reports directly to the Associate Chief of Staff for Education (St. Louis Veterans Administration Medical Center) and the Dean of St. Louis University School of Nursing. The Coordinator for Nursing Education is responsible for the continuing development and enhancement of nursing education, consultation, and research which is mutually beneficial to the St. Louis Veterans Administration Medical Center and St. Louis University.

Qualifications

1. Master's degree in nursing or related field is required with a doctoral degree preferred.

2. Demonstrated administrative ability in a health care or educational setting.

3. Evidence of significant achievements in nursing education and clinical nursing.

4. Evidence of research competence and experience.

5. Demonstrated leadership qualities.

Functions

1. Assessment of short- and long-range nursing service/nursing education needs, and the identification of the methods and resources meeting those needs.

2. Develop mechanisms for the enhancement of mutual planning and collaboration between the Veterans Administration Nursing Service practitioners and the St. Louis University of School of Nursing faculty.

3. Serve as a resource person for the Veterans Administration Nursing Services within Medical District #21.

4. Assist with the development of continuing education programs for the St. Louis Veterans Administration Medical Center, the South Central Regional Medical Education Center, St. Louis University, and the community at large.

5. Assist in the identification of areas of potential nursing research, expansion of nursing roles, and the exploration of funding resources for innovative programming.

6. Participate in the selection of appropriate St. Louis Veterans Administration Medical Center clinical settings to enhance educational opportunities for St. Louis University undergraduate and graduate nursing students.

7. Provide academic and career advisement for registered nurses at the St. Louis Veterans Administration Medical Center.

8. Assist St. Louis Veterans Administration Medical Center registered nurses to further their undergraduate education at St. Louis University School of Nursing through the tuition remission program.

9. Participate in St. Louis University and Veterans Administration Medical Center committees and educational activities.

10. Participate in teaching, consultation, research, and community service activities as appropriate for a faculty member of the St. Louis University School of Nursing.

11. Develop and submit statistical and narrative reports as required by the Associate Chief of Staff for Education, Veterans Administration Medical Center; the Dean of the St. Louis University School of Nursing; and others as requested.

Ohio

Joan Matthews
Director of Nursing
Visiting Nurse Association
2400 Reading Road
Cincinnati, OH 45202

A school of nursing faculty member, who is also a member of the VNA Board of Directors, collaborated with the Director of Nursing in securing the VNA as a clinical placement for a consultation course in the graduate and VNA, the VNA has provided consultative clinical experience to three students during the last year. Although the course has remained essentially unchanged, the focus of the experience has varied, depending upon the student's learning needs and agency staff needs. During two clinical experiences, the focus was patient care with limited home visiting. The third began with a patient care focus but the staff became the client. The student was able to provide consultation about professional identity issues, accountability for problem-solving, and working within an organization to bring about change. Although the length of the experience was limited, the staff perceived the consultation as helpful and used specific recommendations in their decision-making. The student met her educational objectives.

Wisconsin

Lydia Reitman
Madison General Hospital School of Nursing
1010 Mound Street
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The School of Nursing initiated the development of a committee, whose purposes are to facilitate communication between nursing service and nursing education and to mutually plan for student clinical schedules. Members consist of faculty representatives, the curriculum coordinator, and the liaison of the nursing service department. Meetings are held monthly. As a sub-committee of the Curriculum Committee, a report is presented at the regular meetings to keep all faculty updated on their activities. The name of this sub-committee is the School/Hospital Liaison Committee.

Concerns involving student clinical experience are discussed and problem-solved within this group. Two documents: "Guidelines: Planning for Student Clinical Placement" and "Guidelines: Student Attendance at Hospital In-Services" have been developed and implemented. The committee also sponsors serial teas for members of the nursing service organization and the nursing service personnel. The teas and particularly, the structured system of communication, have promoted a more positive and cooperative interrelationship between nursing education and nursing service.

Faculty members voluntarily serve on a variety of hospital committees which may be unit-based or hospital-wide. The opportunity for input into decision-making, afforded through committee membership, has resulted in a mutual sharing of ideas and a broadening of the scope of understanding of particular issues.

Selected faculty have been invited to conduct in-service programs for the nursing service personnel. A formal setting for the exchange of information has served as a note of appreciation for the educational and experiential expertise of faculty.

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